

1994 Trainees' Forum: 'Is general psychiatry dead?'

Fiona Gaughran and Steffan Davies

The 1994 Trainees' Forum was held on the first day of the Winter Meeting of the Royal College of Psychiatrists and was well attended by psychiatrists of all grades. The speakers were Dr David Wilson, Senior Lecturer in Learning Disabilities in Nottingham, Dr Chris Freeman, Consultant Psychotherapist in Edinburgh, Professor Anthony Clare from Dublin, Vice President of the College, and Dr Dinesh Bhugra from London who is secretary of the General Psychiatry section of the College.

Dr Wilson told us that general psychiatrists will survive by being flexible and being able to see the world from another's point of view. Good doctors look, listen and communicate well. Language is very important and the terms 'subspeciality' and especially 'subnormal' are telling in this regard. He suggested a move to life cycle training, starting with puerperal psychiatry and gradually progressing through developmental psychiatry on to old age psychiatry.

Dr Freeman felt that general psychiatry is moribund and we now need to resurrect it. General psychiatrists are too soft on their specialist colleagues, picking up patients that the specialists do not wish to treat. There is no objective evidence that specialisation in psychiatry is of benefit. Psychiatry is not highly technical so there is little need for specialisation and if it occurs it should not be solely on the basis of one major research project. Divisions such as adolescent psychiatry, in addition to being poorly defined, are of little help to a patient with ongoing problems such as learning disability or psychotic illness, necessitating changes of doctors.

If we ourselves were unwell we would first want to see a good general psychiatrist. They have given up the middle ground – instead they should encourage the college to stop specialisation and prize general psychiatrists.

Professor Clare, along with the previous speaker, noted that in-patient state services are effectively now psychotic services. In Ireland, trainees still rotate through the public and private systems, increasing their exposure to non-psychotic psychopathology. The College, however, has tried to turn Irish psychiatry into British psychiatry, pressurising for the development of subspecialties.

Specialisation has got out of hand, perhaps because of our profound unease about exactly who we are. This policy results in subspecialists becoming renowned as specialists while general psychiatrists are deskilled. In the College, subspecialists are a strong body. They speak as 'superspecialists'.

Service structures often dictate the length and composition of training as is now happening within the European Union, reopening the debate once more. What do we want in a general psychiatrist? To be able to assess a wide range of problems, know what they can and cannot do and know who has the specialist knowledge if it is required. General psychiatry is now under pressure from both inside and outside the College but the need for it persists.

Dr Bhugra quoted an old age psychiatrist who said that general psychiatry has been killed by the general psychiatrists themselves. The purpose of general psychiatry remains to alleviate the suffering of human beings and to treat and help patients. We are good at this but must pass this message to patients and other doctors. Objectively, general psychiatry is thriving. One cannot become a subspecialist without being a good general psychiatrist first. It is a paradox that a General Psychiatry Subsection exists at all, but we need to erect a fence around general psychiatry to save it from its killers for if it dies there is nothing left in its place. General psychiatry is good and necessary and will continue to be reborn, albeit perhaps under different names.

A passionate comment from the floor reminded the audience that one of the main stimuli for the formation of old age psychiatry as a specialist section was the poor care that elderly patients often received from general psychiatrists—a comment the speaker felt could be made by all the specialist sections. However, another speaker felt that in the training of psychiatrists the ongoing care of

patients has been sacrificed to a desire to get young doctors to see a bit of everything. It is time for the College to take stock and see if we have the balance right.

Fiona Gaughran, *Senior Registrar; Collegiate Trainees Committee* and Steffan Davies, *Senior Registrar; Chairperson, Collegiate Trainees Committee, Royal College of Psychiatrists*

Membership Examinations

Breach of regulations

It has been reported to the Court of Electors that in the recent MRCPsych Part II Examination, a candidate brought into the examination a personal organiser with a clock function. The Court of Electors wishes to emphasise that candidates must not bring

into the examination any piece of electronic, computer or other equipment. The Regulations have been amended to clarify this and candidates should be aware that any breach of the Regulations will lead to disqualification.

J. L. Cox, *Dean, Royal College of Psychiatrists*

Knowledge of DSM-IV

I am writing to advise candidates and trainers that as from the Spring 1995 Membership Examinations, knowledge of DSM-IV rather than the earlier versions will be expected. You are reminded that candidates are expected to know the principles of classification, to have a

working knowledge of ICD-10 and to have a more detailed knowledge of either ICD-10 or DSM-IV.

SHEILA A. MANN, *Chief Examiner, Royal College of Psychiatrists*

College prizes

The Morris Markowe Public Education Prize 1994 was awarded to Dr Peter M. Haddad from

Manchester Royal Infirmary for an article on 'Postnatal Depression'.
