Correspondence

EDITED BY STANLEY ZAMMIT

In defence of the case report

During his ten years as Editor, Greg Wilkinson worked hard to produce a modern, polished journal with an impressive international reputation. In his valedictory editorial (Wilkinson, 2003) he sets out the goals he has pursued. Almost by definition, an editor cannot receive universal approbation. However, while I suspect that academic/research colleagues will have been happy with his stewardship, many clinicians are likely to have some reservations. The reason for this will be found in three lines in the middle of his final editorial: 'I hastened the demise of the case report, to exclude what I see as psychiatric trivia. I published original research . . .'.

This is a cameo of the polarity that exists between academic, research-oriented psychiatrists and those clinicians who provide the bulk of the service in the National Health Service. They confirm the contemporary ethos that the only worthwhile form of study is that of groups. The nomothetic approach takes precedence while the detailed study of an individual patient is marginalised as trivia.

Psychiatry is not unique in having been seduced by the scientific process. Unfortunately, it is doubtful how much the practice of our discipline has gained from this development (Shooter, 2003; Wilkinson, 2003). This is not surprising. Psychiatry is a discipline in which the information is 'soft' and much of it subjective. In contrast, the scientific approach insists that any parameter of illness that cannot be measured in terms of hard data is suspect.

As academic psychiatrists have become more influential within the profession and training is more university based, research and related activity are seen as the acme of psychiatric work. Working closely with patients and creating enduring therapeutic relationships is not valued and is sometimes seen as drudgery. This is a damning paradox. Is it surprising that it is hard to recruit into psychiatry – a specialty that is dismissive of the very core of its professional ethic?

Psychiatry needs to return to its core values (Simms, 2003). It needs to place the care and treatment of the individual patient centre-stage. Students, young doctors and psychiatric trainees must see at first hand the fascination and reward of working with patients, and see that the work is attractive and satisfying. A part of this process must be the rehabilitation of the detailed case report.

Shooter, M. (2003) On Pushto, principles and passion: just what is an advance in psychiatric treatment? *Advances in Psychiatric Treatment*, **9**, 239–240.

Simms, A. (2003) 'Back to basics': on not neglecting the elementary in continuing professional development. *Advances in Psychiatric Treatment*, **9**, 1–2.

Wilkinson, G. (2003) Fare thee well – the Editor's last words. *British Journal of Psychiatry*, **182**, 465–466.

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In defence of specialist mental health care trusts

Psychological medicine is an interesting way to describe an attractive field (Lloyd & Mayou, 2003). The patients are generally interesting and engaging, the work is usually consensual and professionally rewarding. However, when mental health services are attached to general hospitals, liaison psychiatry is merely one of an array of specialties competing for funds. Commissioners may find that more acute, high-profile services that are better supported by the public take priority when it comes to the annual funding round.

A failure to secure sufficient funds in this situation can lead to psychiatric wards and facilities appearing neglected and shabby compared with general medical wards in the same hospital. When coupled with a staff that is liable to feel undervalued, the quality of care can suffer and the stigma of mental illness is compounded.

The appearance of specialist trusts in many different areas of medicine should allow the strategic, systematic development of a comprehensive range of specialist services. Lloyd & Mayou should welcome the opportunity to develop their field in such a focused setting along with other psychiatrists with different interests. By seeking to 'make itself [liaison psychiatry] more acceptable to medical colleagues' they could be distancing themselves from the 'psychotic patients [historically] housed in large asylums'. These are the very patients that suffer the greatest amount of stigma and social exclusion, that form the bulk of most psychiatrists' case-loads and that are the least visible to general hospitals.

All psychiatrists should have the opportunity to develop their skills by caring for this group of patients as part of their training. It would be a pity if the views of Lloyd & Mayou were taken to their logical conclusion and 'psychological medicine' divorced itself from mainstream psychiatry and sought to become recognised as a sub-specialty with our esteemed colleagues at the Royal College of Physicians.

G. G. Lloyd & R. A. Mayou (2003) Liaison psychiatry or psychological medicine? *British Journal of Psychiatry*, **183**, 5–7.

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Mental incapacity and medical ethics

With reference to the editorial by Sarkar & Adshead (2003), we are pleased to see this area of discussion being raised. However, we wish to make a couple of additional points relating to capacity.

We appreciate that a psychiatrist's ability to override a competent refusal raises particular ethical dilemmas and it is right that this should be highlighted for attention. However, we felt that other points in the section 'Psychiatry as a special case' could, and do, apply to many non-psychiatric patients, particularly those with acute medical illness.

The authors assert that 'The most significant difference between medicine and psychiatry lies in the relative incapacity of psychiatric patients to make decisions for themselves'. Although it is true that some

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