

Editorial

The future of psychiatry

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**Summary**

There is widespread concern among psychiatrists that the profession is in crisis and that it faces an array of external and internal challenges. Indeed, some observers have questioned whether the psychiatrist is an endangered species. This paper argues that medical specialties can become extinct as the case of the apothecaries exemplifies. The training template for psychiatry in the UK was put in place 40 years ago and there is a need to carefully examine whether it is still fit for purpose. Advances in theoretical knowledge and in basic understanding of psychiatric

disorders have not significantly influenced the structure of clinical placements; rather it is service developments and administrative demands that have been the determinants of changes in training. Urgent action is required to address the need for reform of training that will ensure the future of psychiatry as a profession.

Declaration of interest

None.

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The rise and fall of apothecaries

The Charter of the Worshipful Society of Apothecaries of London, which was granted in 1617, gave apothecaries control over the 'Art and Mystery of the Apothecary within the City of London, the Liberties and Suburbs thereof and within seven miles of the same City'¹ and was extended in 1815 to the right to practise beyond London to the whole of England and Wales. A study of the rise and fall of apothecaries as a profession is instructive. The apothecaries separated from grocers in 1617 and between 1545 and 1743, there were 500 registered members of the Barber-Surgeons' Guild in Bristol, of whom 250 were apothecaries and 36 were physicians. Over the next 50 years, the number of apothecaries decreased sharply so that by 1793 only 35 apothecaries remained.¹ During this period the role of the apothecaries included giving general advice and a range of services now provided by general practitioners, community pharmacists and dispensing chemists.

The decline in the status and role of apothecaries was partly due to the encroachment of druggists on the traditional trade of apothecaries.² The Society of Apothecaries granted licences to practise medicine from 1815 onwards and from 1886, following the Medical Act, this was the Licence in Medicine and Surgery of the Society of Apothecaries. The Licence in Medicine and Surgery of the Society of Apothecaries continued to be granted until 2003. But where are the apothecaries today? And, can the history of the apothecaries serve as an illustrative case in point for psychiatrists who are concerned about the challenges to their profession?

The challenges facing psychiatry

The challenges to psychiatry have been well described and include the de-medicalisation of healthcare within mental health services,

the marginalisation of psychiatrists in service development and organisation, and the assault on professionalism, clinical autonomy and self-regulation.³ Furthermore, there is a sense that psychiatry as a profession is in crisis and this is exemplified by the different theoretical orientations within psychiatry, the debate on the nature of psychiatric disorders, the claim by some that both antidepressants and antipsychotic agents are ineffective and the stigmatisation of the profession.^{4–5} Despite these problems, implicit in the discussions is the assumption that the profession of medicine is immutable and that since human beings will always need medical care and attention, the profession of medicine and specialties such as psychiatry will continue to flourish. But, as the case of the apothecaries demonstrates, human ailments and suffering can be alleviated by new professions, and old professions can and do become extinct.

Aside from the challenges to the profession from politicians and the wider public, there are threats to all medical specialties that derive from changes in patterns of diseases, advances in knowledge and medical technologies. The need for thoracic surgery of the kind that dealt with bronchiectasis, pulmonary tuberculosis and empyema is much less today than it was. There has been a shift in the role of dermatologists from being pure physicians to taking on surgical roles and radiologists have ceased being merely responsible for interpreting the results of investigations to becoming active interventionists in their own right. These examples show that medical specialties need to adapt, sometimes rapidly, to changes in the environment. In addition to these challenges, there are the interprofessional rivalries within the healthcare economy. Within mental health there has been a proliferation of professions over the past 50 years including clinical, counselling, health and forensic psychologists respectively. In the UK, there are also graduate mental health workers, gateway workers, psychological well-being practitioners, high-intensity psychological therapists, all of whom contribute in some way to the care of people with emotional distress. Neurologists and geriatricians too are taking an interest in the assessment and care of individuals with dementia. In the light of these tests to the role of psychiatrists it is our opinion that psychiatrists ought to review their place within medicine, their function and responsibility within mental health services, in order to determine the scope and limits of their position.

If psychiatry is not to go the way of the apothecaries, the profession must take steps to plan for the future, informed by a vision of how advances in scientific knowledge and basic

understanding of mental illnesses will influence how psychiatric conditions are assessed and managed. The template that guides training to date was set in place in 1971 when the Royal College of Psychiatrists was formed. The academic content and particularly the structure of clinical placements have not been radically altered in 40 years. We would argue that developments in the workplace have had more influence on training than academic developments. Trainees now have placements in teams such as crisis teams, assertive outreach teams, home treatment teams and in-patient teams even though there is little evidence that the academic or clinical experience derived from these placements are unique enough to stand as discrete training opportunities. And it is possible for a psychiatric trainee to complete their training with only the most minimal exposure to in-patient clinical work. On the other hand, advances in the interfaces between psychiatry, neurology, geriatrics, cardiology, immunology and endocrinology have not influenced clinical placements to any significant degree. Although our focus is on clinical practice, there are important issues regarding advances in theoretical knowledge and as Bullmore *et al* posit, given the centrality of neuroscience to psychiatry, it is arguable that mainstream British psychiatry is retreating to a neurophobic position.⁶

Our aim is to draw attention to the challenges to the integrity and identity of the profession. Unique clinical functions, such as the prescription of medication, or the statutory duties reserved under the mental health legislation of the day to the responsible medical officer, are no longer sacrosanct. While research and academic investigation are able to show biological correlates in an increasing range of psychiatric disorders we have moved from the traditional terminology of medicine and conceptualisation of disease, where doctors see and treat patients, towards the language of consumerism, to the service user and the client, apparently striking at the basis of psychiatry as a medical and scientific discipline. At times we may even shy away from the use of the word psychiatry itself, or of mental illness, to talk about mental health when we very definitely mean mental illness.

Recommendations

This is not the place to design the academic content and clinical placement structure for training in psychiatry. Bullmore *et al* have put forward proposals for strategic action that we support.⁶ Our emphasis is on clinical placements both to underscore the importance of clinical medicine to psychiatry and *vice versa* and to further the exposure of trainees to subjects that will undoubtedly influence practice in the future. We would argue that psychiatric trainees should have clinical placements in neurology,

as is the case in continental Europe, preferably within the first year of training. In addition, placements or electives in other medical specialties such as cardiology, endocrinology and immunology should be part of higher professional training. Old age psychiatric trainees ought to have placements in geriatric medicine. These proposals can be implemented quite rapidly and only need strategic thinking and determination to effect. There are implications for the MRCPsych examinations, the most obvious being the need for relevant clinical medicine content in the theoretical papers and in the clinical examination. There are also implications for the continuing professional development of consultants that may require a College-sanctioned curriculum. To this end, the College ought to set up as a matter of urgency a committee to examine these matters and to report to Council with the explicit aim of reforming both the theoretical content of training and the structure of clinical placements.

The enduring gift of the Society of Apothecaries to British society is the Chelsea Physic Garden and very few people are aware of its connection to the Society of Apothecaries. Our aim is to ensure that psychiatry with all its strengths and contributions to medicine should not go the way of the apothecaries.

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