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Letter

The Rosen–Cunningham debate: another, alternative view

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I would like to add decades of my personal psychiatric experience to those of Rosen *et al.*[1] and their critic, Cunningham.[2] In my view, neither community-based treatment (including the 'one-stop community shop') nor in-patient treatment, backed up by hospital-based emergency triage, as presently conceived, can ever provide the quality of psychiatric service that one would expect in any other medical speciality. Arguments for or against community psychiatry vis-à-vis hospital psychiatry, while fundamental, fail to address an even more fundamental issue. This is less where patients are treated, or even how, but by whom.

In neurosurgery, only a neurosurgeon is permitted to conduct surgical treatment. In psychiatry, the medical specialist is increasingly regarded as a consultant to a panoply of non-medical therapists, themselves subservient to a mental health team. Neurosurgeons, of course, work in teams, but only the medical team wields the scalpel. In psychiatry, the physician is virtually the last one to treat. Even were one to secure funding and staffing for a suitably balanced community-come-hospital-based treatment service, that service could only ever be as good as its professional medical staff. It may be argued that psychiatrists, in their consultancy role, should be able to maintain standards. In practice, cases routinely pass under the radar. A staff handover, either face-to-face or at a team meeting, is no substitute for hands-on professional psychiatric care. Nor is a letter from a psychiatrist informing a general practitioner of a psychiatric patient plan. Surgery, when conducted under supervision, including when conducted remotely by telemedicine, is still surgery by surgeons.

Many would argue that funding of psychiatrists, even if it were politically and practically possible, is passé. I believe that if that is the case, then psychiatry too is passé. In the mental health era, the complexities of its psychopathology, its nosology and its treatments are giving way to dumbed-down manuals, which purport to enable non-medical therapists to manage cases with an indivisible, core medical element. In the biomedical and neuroscientific era, the teaching and research of psychiatry are being led by basic scientists rather than by physicians. Psychiatry is in the process of being dismantled. Even if acute care needs were met from the two epicentres, community and institutional, treatment would only be adequate if its practitioners were adequate.

My view will doubtless be countered by those who eschew a return to what they regard as medical hegemony. Even if there were a place for non-medical practitioners in psychiatry (and I believe that it is far less than it has become), the medical element has shrunk far below the level necessary for psychiatry to be a credible medical speciality.

References

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2 Cunningham PA. The future of community-centred health services in Australia: an alternative view. *Aust Health Rev* 2012; 36: 121–4. doi:10.1071/AH11013