

severe mental illness as opposed to 'mental health problems'. The latter may not require specialist psychiatric input as medicalising problems of living is clearly undesirable.

The centrally driven 'one size fits all' approach to 'modern' service delivery has left many patients with serious psychiatric illness bereft of the clinical expertise and leadership to effectively manage their condition. Notions of complexity (undefined) and risk have superseded diagnostic context. The 'diffusion of responsibility' as conceptualised in New Ways of Working often leads to unfocused care plans and risk management assessments without the one element essential to modifying any risks – that is, effective psychiatric treatment based on a comprehensive diagnostic formulation and understanding of the nature of the illness. Accurate diagnosis not only allows appropriate treatments for individual patients but also prioritisation of resources in service delivery. Furthermore, a diagnostic threshold is an essential requirement of the Mental Capacity Act in the assessment of capacity of our most vulnerable patients.

Major changes in psychiatric management and service structure have been introduced that are mostly not evidence based and certainly not consequent upon real advances in treatment. The political dimension to this process makes constructive criticism difficult. The letter to *The Times* from Kinderman and members of the New Ways of Working Care Services Improvement Partnership and National Institute of Mental Health exemplifies this.² In response to the article by Craddock *et al* they refer disparagingly to the 'traditional medical model' in contrast to 'modern mental healthcare' which is a 'collaborative team effort' as if the medical model concerns itself only with medical matters in the most narrow sense. They also suggest that some psychiatrists are unable to 'cope with the loss of hegemony' and refer by implication to Craddock *et al* as demonstrating 'intellectual arrogance . . . and assumptions of superiority'. Their response to put it mildly offers little basis for constructive debate and has previously been described as 'messianic' in tone.³

Like many psychiatrists engaged in the treatment of serious mental illness and organic brain disease we look to our professional body the Royal College of Psychiatrists for a lead but find our views are not adequately represented.

- 1 Craddock N, Antebi D, Attenburrow M-J, Bailey A, Carson A, Cowen P, Craddock B, Eagles J, Ebmeier K, Farmer A, Fazel S, Ferrier N, Geddes J, Goodwin G, Harrison P, Hawton K, Hunter S, Jacoby R, Jones I, Keedwell P, Kerr M, Mackin P, McGuffin P, MacIntyre DJ, McConville P, Mountain D, O'Donovan MC, Owen MJ, Oyeboode F, Phillips M, Price J, Shah P, Smith DJ, Walters J, Woodruff P, Young A, Zammit S. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.
- 2 Kinderman P, Vize C, Humphries S, Hope R. Modern mental healthcare is a team effort [letter]. *The Times* 2008; 3 July.
- 3 Lelliott P. Time for honest debate and critical friends. Commentary on . . . New Ways of Working. *Psychiatr Bull* 2008; **32**: 47–8.

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I would like to provide a medical student's perspective on the paper by Craddock *et al*.¹ I am about to enter my 4th year of medicine (having just completed an intercalated BSc in psychology and medicine) and will soon have my first real exposure to clinical psychiatry. Although I am keen on psychiatry, the majority of my fellow students are happy to express disdain at the thought of a psychiatric career. It is obviously difficult to say

why this might be the case but something is clearly amiss in the way that psychiatry is being presented to tomorrow's doctors.

During my BSc, it was interesting to gain insight into the opinion that psychologists have of psychiatry, which unfortunately was one of 'over-medicalisation' and neglect of psychosocial factors. For me, this reiterated the importance of early positive interaction between the two professions and a need for better understanding of each others' strengths. Perhaps this interaction is best initiated during undergraduate training?

More importantly, and from the angle of a card-carrying wannabe psychiatrist, this paper has confirmed that clinical psychiatry is attractive to me not because it is excessively reductionist but because it deals with the complex interplay between psychiatric (and non-psychiatric) illness and countless important psychosocial factors. Furthermore – and this may be the blind optimism of youth talking – I hope to become an excellent physician who is trusted and respected by her patients. Because of this, I am not discouraged by those who fail to consider psychiatrists as 'proper doctors', although it is clear to me that this negative view by other doctors acts as a deterrent for some of my colleagues who might have been interested in a psychiatric career.

Finally, on a more anecdotal note, I have the perspective of someone who has lost a relative because of failure in psychiatric and non-psychiatric care and social support. Had an appropriate (and properly functioning) multidisciplinary team been in place, both in assessment and management, I believe that the outcome would have been very different. So in response to the question 'if a member of your family were a patient, is a distributed responsibility model the one for which you would opt?' my answer would be an uncertain 'ummm, I think so', so long as this included the appropriate level of assessment and involvement of a senior psychiatrist alongside other professionals.

- 1 Craddock N, Antebi D, Attenburrow M-J, Bailey A, Carson A, Cowen P, Craddock B, Eagles J, Ebmeier K, Farmer A, Fazel S, Ferrier N, Geddes J, Goodwin G, Harrison P, Hawton K, Hunter S, Jacoby R, Jones I, Keedwell P, Kerr M, Mackin P, McGuffin P, MacIntyre DJ, McConville P, Mountain D, O'Donovan MC, Owen MJ, Oyeboode F, Phillips M, Price J, Shah P, Smith DJ, Walters J, Woodruff P, Young A, Zammit S. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.

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Craddock *et al*¹ call for the restoration of the 'core values' of biomedicine – diagnosis, aetiology and prognosis – despite evidence that such concepts have delivered little more than stigma and helplessness.² A generation ago, Mosher demonstrated that contrary to received opinion, the recovery of people with schizophrenia could be enabled with no more than sophisticated psychosocial support.³ Since then the role of personal, social and environmental factors in generating 'breakdowns' and 'fostering recovery' has become widely accepted. The 'mental well-being' train has left the station and in many places is close to its destination.

Craddock *et al* advocate a 'more positive and self-confident view of psychiatry', but complain that 'many people . . . have developed exaggerated and unrealistic expectations'. Clearly, psychiatry's reification of diagnosis, with the implication of effective treatment, fostered such expectations. The comparison of mood disorders with heart disease serves as an illustration. Much of the emergent distress within high-income nations has more to do with lifestyle, values and other psychosocial factors,