than anything resembling biomedical pathology. If the global burden of depression is to be lifted, it will require more than specifying more 'clearly the key role of psychiatrists'.

Although Craddock *et al* were clearly offended by talk of mental health and well-being, this focus is long overdue. Talk of 'mental illness' and 'our patients' is regressive and paternalistic. On the 60th anniversary of the NHS it should be unnecessary to advocate well-being as the purpose of healthcare. Mental health advocacy joins the abolition of slavery, votes for women, feminism and gay rights as another example of emancipation within Western society. The 'service user' title may be unsatisfactory, but is another linguistic step towards acknowledging that people are the agents of their lives. They must be addressed as persons if genuine emancipatory mental healthcare is to become a reality.

The learning disabilities field provides a precedent. A generation ago, most people with significant forms of 'mental sub-normality/deficiency' lived in hospitals under the care of psychiatrists. Today, despite the influence of genetic anomalies or organic disorders such people live in natural communities, albeit with broad-based psychosocial support. Some may have occasional need to consult physicians, but their lives no longer revolve around their diagnosis. This change in philosophy did not devalue psychiatry but did acknowledge that all problems in human living affect persons. All talk of psychiatric treatment should follow suit, embracing the word's original meaning: the 'manner of behaving towards or dealing with a person'.[4]

Regrettably, Craddock *et al*'s rallying call will be offensive to many service users who have struggled to detach themselves from the more unfortunate aspects of traditional psychiatry. It will also be dispiriting to many of their colleagues. Craddock *et al* may be surprised to discover that nurses have already joined psychiatrists as statutory prescribers of medication,[5] and some clinical teams recognise the virtue of electing the professional best qualified to inspire and nurture the team.[6] Time, perhaps, to wake up and smell the coffee.

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, Oyebode 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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I thoroughly enjoyed the Editorial by Craddock *et al*,[1] and would like to address the following points. First, the perceived 'lack of recruitment and retention in psychiatry'. Though there has been considerable mention of this, anyone involved in psychiatric training or workforce planning recently will be aware of the changes in numbers in the years since systems such as New Ways of Working[2] were conceptualised. What has not been mentioned (and what is more pertinent) is the effect of such changes on future recruitment and retention.

Second, the educational standards that we, as trainees, are expected to achieve are laudable, and (justifiably) a great deal of effort has been spent over the years by the Royal College of Psychiatrists to refine these (a recent example being the curriculum submitted by the College to the Postgraduate Medical Education Training Board). The delegation of assessment to multidisciplinary team members, without adequate, standardised assessment of competency, is worrying. Clinical experience has shown that GPs, when they refer patients, might not have conducted an exhaustive neurological examination or battery of tests to exclude organic causes, and would expect these to be picked up by secondary services. It is beyond the boundaries of reason (and team supervision) to expect multidisciplinary team members to be aware of organic presentations, neuroendocrine signs and symptoms, and subtleties on history and mental state examination that come with the experience (and training) of a psychiatrist. The equivalent would be a neurology service expecting a physiotherapist to assess patients referred with unexplained weakness and muscle atrophy; certainly the physiotherapist may have an important, specialised role in treatment, but the initial assessment should be by a physician, who will have a broad knowledge base, refined by training and experience.

Our patients present in complex ways and to reduce their assessment to rating scales, symptom checklists and risk management (as is currently the vogue) makes a mockery of the skills needed to practice psychiatry to an adequate standard. By delegating initial assessment to generic team members, the art of psychiatry appears to have been reduced to a 'paint by numbers' approach, that is anything but patient-centred. Looking at the fashion in which changes have been implemented, it is easy to make comparison with other Department of Health initiatives (such as the Medical Training Application Service/Modernising Medical Careers fiasco[3]). On this occasion, however, the College has the opportunity to effect change. The gauntlet has been thrown to the College to poll its membership on the implementation of New Ways of Working; this issue will not go away and needs to be resolved.

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, Oyebode 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 Department of Health. *New Ways of Working for Psychiatrists. Enhancing Effective, Person Centered Services Through New Ways of Working in Multi-disciplinary and Multi-agency Contexts. Executive Summary of the Final Report 'but not the end of the story'*. Department of Health, 2005.

3 Tooke J. Aspiring to Excellence. Findings and Recommendations of the Independent Inquiry into Modernising Medical Careers (http://www.mmcinquiry.org.uk/MMC_Inquiry_Launch_2.pdf). MMC Inquiry, 2007.

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