Unfair playing field

I fully agree with the change of the name of *The Psychiatrist* to the *Psychiatric Bulletin*.[1] The phrase 'unfair playing field' is very important. For the past 50 years in psychiatric publishing it would appear that there were serious conflicts of interest not declared. For example, an editor and reviewers have reviewed papers where they are competing for research funds in the same areas as the papers submitted. In addition, many of these same people have been on committees deciding on funding for research in the same area as the paper that is being submitted or have other associations with the authors of the paper of one kind or another. Serious conflicts of interest particularly related to the 'golden circle' of people who are both editors, submitters of papers and on funding bodies. This controls what is allowed to be published and what topics are allowed to be funded and has damaged research and publication in the past 50 years. In a way it seems as if 'might is right' – the mighty being inside the golden publishing circle. It would be interesting for somebody to do a review of publications in psychiatry journals for the past 50 years to see where these conflicts of interest occurred and were undeclared. It is probably a more sociological task.

1 Pimm J. Scientific publishing – an unfair playing field. *Psychiatrist* 2013; **37**: 281–2.

Michael Fitzgerald, Psychiatrist, Trinity College, Dublin, Ireland, email: prof.m.fitzgerald@gmail.com

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I welcomed the October 2013 issue of *The Psychiatrist*.[1] The juxtaposition within it of the views of the Editor and the reprint of an interview with Professor Lishman gave me hope that there may be a stronger attempt to address the 'complete disconnect between research and clinical practice, with a relentless tendency over many years to downplay the medical and biological aspects of mental healthcare'. These are the words of Peter Tyrer, then Editor of the *British Journal of Psychiatry*, in its bicentennial volume.[2]

The nearer mental illness – not mental health – can be made congruent with the position in society held by other physical illnesses, the sooner will its stigmatisation lessen. This happened with cancer, tuberculosis, epilepsy, and now belatedly is being applied to AIDS. As indicated in the Editor's critique, the same standards must be applied to the criteria used to select matter for the *Psychiatric Bulletin* as are used in other medical scientific journals.

Prior to this edition I was consistently dismayed by the preponderance of matters related to quantitative differences in services and individual traits rather than research for reliable, generalisable tools of diagnosis and treatment. Psychiatry is to do with the qualitative analysis of disease, not supporting the vagaries of personalities within society. The latter are the province of education, psychology, sociology and the law. Of course, all the professionals of these disciplines require the sort of psychotherapeutic skill that Professor Lishman uses – distributive – that helps people to be brought into useful relationship with the therapist and his special tools. His career epitomises to me what psychiatry, psychological medicine, is properly about.

Incidentally, my own slight difference with Professor Lishman relates to his view of Willhelm Greisinger. Greisinger throughout his book emphasises that humanitarian care is a given in serving the needs of the mentally ill. In the first paragraph of his chapter on therapeutics he applauds the 'great principle of humanity' in psychiatry. However, he made it clear that in the light of the increasing knowledge of the 'morbid action of the brain' humanitarianism will not of itself correct the abnormalities of brain function that underlie disease.

Sadly, this has proven true. Mental illness has remained one of the last areas to develop effective treatments. This is the basis of the remaining stigma. Furthermore, the overarching use of the term 'mental health' has unfortunately set psychiatry into a 'non-disease' ecology and has thus in my view obfuscated the way of progress within the specialty. We need to address this 'relentless tendency . . . to downplay the medical and biological aspects of mental health care'.[2]

1 Pimm J. Dear Editor, why have you rejected my article? *Psychiatrist* 2013; **37**: 313–4.

2 Tyrer P, Craddock N. The bicentennial volume of the *British Journal of Psychiatry*: the winding pathway of mental science. *Br J Psychiatry* 2012; **200**: 1–4.

John Elliott FRCPsych, consultant psychiatrist (retired), Birch Hill District General Hospital, Rochdale, email: jjtelliott@aol.com

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Workplace-based assessments need trainer consistency

Despite their many criticisms, I am in favour of workplace-based assessments (WPBAs). They do, in theory, assess a range of important skills and do this outside of stressful examination conditions, thereby allowing trainees to perform to their greatest ability. The Assessment of Clinical Expertise (ACE) in particular covers many of the same skills assessed in the long case but avoids the snapshot examination the latter was often criticised for. The ACE overcomes this by assessing patients across multiple specialties with varying patient groups and attempts to minimise examiner bias by requiring completion from a number of different trainers. It also supersedes the long case by allowing full observation of the patient encounter and so in addition to assessing diagnostic and management skills, provides a more reliable means of assessment of communication skills and the ability of the trainee to develop a rapport with their patient.

As a trainee, however, I can clearly see that WPBAs are not without their problems. The main concern for myself and many trainees alike is not with their format or the skills they assess, but rather the rating and feedback. There is lack of consistency among trainers in completing these forms with no standards of reference to work to and so there is great subjectivity in their completion. Perhaps the introduction of external assessors who have received further training could be a step forward in overcoming such inconsistencies.

1 Michael A, Rao R, Goel V. The long case: a case for revival? *Psychiatrist* 2013; **37**: 377–81.

Yasmine A. Nasr, CT1 Psychiatry, Birmingham and Solihull Mental Health NHS Foundation Trust, email: yasmine.nasr@bsmhft.nhs.uk

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