Rediscovering General Psychiatry: Creation of an Academic Division

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Objective: To describe the rationale, origins, and goals of a newly created academic division of general psychiatry within a university setting.

Method: Literature review, observation, and description.

Results: Within 2 years of its inception, the General Psychiatry Division of the University of Toronto has begun to realize some of its goals and further elucidate specific objectives.

Conclusions: In an era of increasing academic subspecialization, the preservation of core skills in psychiatry and the recognition of the continuing public need for psychiatric generalists must be enshrined within academic training programs.


Key Words: psychiatry, education, residency, generalist

In 1994, a forum held at the Winter Meeting of the Royal College of Psychiatrists in England centered around the question “Is general psychiatry dead?” (1). One of the participants was described as arguing that “general psychiatrists are too soft on their specialist colleagues, picking up patients that the specialists do not want to treat. There is no objective evidence that specialization in psychiatry is of benefit. Psychiatry is not highly technical so there is little need for specialization and if it occurs it should not be solely on the basis of one major research project” (1; p 121). Another speaker commented that “one cannot become a subspecialist without being a good general psychiatrist first. It is a paradox that a General Psychiatry Subsection exists at all, but we need to erect a fence around general psychiatry to save it from its killers for if it dies there is nothing left in its place” (1; p 121).

While this forum did not generate specific solutions, the fact that it occurred suggests a tension within psychiatric training that crosses national boundaries.

Similarly, in the United States there has recently been a call to redefine the general psychiatrist. Beigel and Santiago (2) call for a new set of values for general psychiatrists that increase emphasis on multidisciplinary teamwork; complex cases which traverse boundaries between medicine and psychology; the severely mentally ill; and the role and delivery of psychotherapy, “some of which can be effectively delivered by nonmedical mental health professionals” (2; p 770). In order to achieve this, the authors suggested curricular reform that included a wider range of training settings such as community support programs and family practice clinics; more formal training in multidisciplinary teamwork and the nature of leadership; more awareness of service use patterns and implications as well as fundamentals of quality assurance; improved expertise in psychopharmacology; increasing comfort with, confidence in, and commitment to working with chronically mentally ill patients; and retaining psychotherapy as a core skill but placing more emphasis on a variety of short-term interventions and balancing it with skills such as crisis intervention, complex diagnostic assessment, pharmacotherapy, and consultation to primary care providers.

Over the last 3 decades, the Department of Psychiatry at the University of Toronto has grown into the largest such department and residency training program in Canada and one of the largest in North America. It currently includes 500
full- and part-time faculty members and provides training for 120 psychiatry residents, 35 fellows, and many additional allied health professions students. The development of such a complex department, spread over 17 hospitals and additional clinical and academic facilities, has been accompanied by the evolution of areas of focal academic interest into a matrix that includes the following subspeciality divisions and programs: child psychiatry; geriatric psychiatry; women’s mental health; forensic psychiatry; psychosomatic medicine; culture, community, and health; mental health systems delivery; psychotherapy; mood disorders; schizophrenia research; drugs and alcohol; and psychopharmacology. While there is inevitable overlap between these categories from clinical, research, and training perspectives, their separation has been a helpful academic exercise in scholarly development, as reflected by recruitment of a critical mass of colleagues, research grants and publications, innovative clinical programming, and new subspecialty training opportunities.

The size and resources of this university department have clearly facilitated its expansion into subspecialty areas in ways that parallel the developments in medicine, pediatrics, and surgery years earlier. With such subdivision of a specialty, however, comes the risk of losing the core of the field—and losing sight of community needs. A further risk is that the trainee who does not opt for a subspecialty career feels or is devalued from an academic perspective. Admittedly, this problem may be less prominent for smaller training centres where opportunities for subspecialty training are less abundant.

The impetus to develop a general psychiatry division within this complex matrix evolved from both internal and external needs and pressures. In 1992, the Committee on Psychiatric Education, a national body comprised of all university-based postgraduate education directors in psychiatry and elected residents, created a set of training objectives for adult general psychiatry. These objectives far exceeded the delineated expectations of the Royal College of Physicians and Surgeons of Canada (RCPSC), which call for a year of general hospital psychiatry training in residency, in that they included specific objectives in the areas of knowledge, skills, and attitudes. That same year, an internal document prepared at the University of Toronto Department of Psychiatry entitled “Fulfilling Our Public Trust” examined ways in which the department might “increase the number of psychiatrists who work in areas of unmet need.” The first recommendation of this report was the creation of a general psychiatry division with clear objectives for training both junior and senior residents as well as a commitment to continuing medical education for hospital-based psychiatrists across the province. Within 6 months of that report, a general psychiatry division was established, a division head selected (DG), and the task of developing an academic program initiated.

Thus the currents of change fomented with regard to general psychiatry can be seen as stemming from 2 principal sources: increasing subspecialization within the field and increasing awareness of public need for particular psychiatric services. A third factor that is driving the process of transformation is the perception and reality of general psychiatric practice. In 1992, a researcher reviewed perceptions about psychiatrists between 1941 and 1990 as reflected by their representation in magazine cartoons (3). Interestingly, someone has attempted this task every decade since 1950 and has published the results in peer-reviewed journals. In the 1992 study, 404 cartoons were reviewed and clustered by decade. The result was clear; there has been no appreciable change in the profile of the cartoon psychiatrist’s appearance, behaviour, treatment methods, or efficacy in the past 50 years. It raises the question of whether it is the perception or the reality that is static. A 1991 survey of the graduates of psychiatry residency training programs between 1980 and 1989 in Ontario (Garfinkel and Voineskos, personal communication) revealed graduates of the University of Toronto program to be the most likely to practice a stereotype of cosmopolitan psychiatry. They were more likely than graduates of other programs to work in a private office seeing individuals with personality disorder in psychotherapy; they were correspondingly less likely to provide indirect patient care, work in provincial psychiatric hospitals, work with inpatients, the elderly, or families, prescribe antidepressants, anxiolytics, or antipsychotics, and see new patients; and they carried smaller case loads, presumably for more intensive individual treatment. As pointed out recently by Dr William McCormick, past president of the Canadian Psychiatric Association, while the total number of psychiatrists practising in the province of Ontario well exceeds the numbers recommended by both governmental and professional guidelines, there remain over 100 vacancies for psychiatrists in general hospitals across the province (4). This problem relates not only to geographic maldistribution but also to the issue of practice patterns. The general psychiatrist had become primarily a psychotherapist, and the balance between direct patient care and the consultant role of a specialist was askew.

Before one charts the course for general psychiatry, it is instructive to examine developments in general internal medicine, general pediatrics, and general surgery. A symposium entitled “General Internal Medicine in the 21st Century” was convened at the annual meeting of the RCPSC in 1993 (5). It followed 2 decades of evolving importance of internal medicine subspecialties and led to the following definition of the roles of the general internist: patient-centred clinician liaising closely with both primary care and subspecialties and often dealing with either undifferentiated or multisystem illness; teacher at all levels of clinical skills and application of evidence-based care; researcher in such areas as accuracy and cost-effectiveness of diagnostic evaluations and
therapeutic decisions, ethics, quality assurance, clinical pharmacology, medical informatics, and medical education; administrator in hospitals, university departments, communities, and professional associations.

Two types of general internists were defined: community-based and university-based. Both may serve as important role models for trainees. The symposium concluded with a call for academic divisions of general internal medicine in all university training programs with defined training objectives, opportunities for community-practice exposure for trainees, and a strategy for continuing medical education. A survey of practitioners of general internal medicine in Ontario (6) provided empirical data on the nature of their professional activities and their perceptions of how their professional satisfaction might be improved. Apart from specific suggestions for curriculum reform and fee schedule reform, the survey revealed that positive interactions between physicians and their patients contributed most to practice satisfaction—a reassuring finding.

In the United States, Dr Robert Petersdorf of the American Association of Medical Colleges has called for a bolstering of general internal medicine—but he defines the general internist as a primary care provider in competition with, rather than a consultant to, family physicians (7). While elements of the diagnosis of the problems for general internal medicine are different in the United States—particularly with regard to market forces and third-party payment—the cures have elements of similarity to those proposed in Canada. They include a more prominent role for community-based exposure to general internal medicine practitioners and mentors; a greater role for general internists within the university hierarchy; a deemphasis in subspecialty internal medicine residencies and fellowships; and a decrease in academic prejudice toward primary care careers. At the same time, Petersdorf rails against “certifimania” within internal medicine, in contrast to his Canadian colleagues and in contrast to trends in psychiatry, where each emerging subspecialty seems to wish for its own examinations, diplomas, secret handshakes, and decoder rings! Finally, the Federated Council for Internal Medicine issued a position paper in 1992 (8) that recommended bolstering of the scholarly basis of general internal medicine through health services research, clinical epidemiology, and educational sciences to give them the “credence and academic prestige . . . now extended to research in the basic medical sciences” (8; p 779).

In pediatrics, the development of academic general pediatrics was significantly strengthened in 1978 by a $10-million grant from the Robert Wood Johnson Foundation to 6 university pediatrics programs for 10 years (9). This mammoth effort was described by Robert Haggerty as “an ambitious attempt to revive the academic general pediatrician,” whom he described as “an endangered species” (9; p 413). He observed that in the past, academic pediatricians had trained and practised somewhat as generalists while pursuing subspecialty interests, but current academic faculty are clinically focused exclusively on their subspecialties. As a result, he felt that “patients complain of difficulty in knowing which subspecialist they should see. Research and teaching often do not address common or multisystem problems as often as seems desirable” (9; p 413). He defined 4 principal roles for the academic general pediatrician: expert clinician (for which he notes an absence of role models); researcher in epidemiology, behavioural sciences, and evidence-based medicine; teacher at all levels including continuing education for practitioners; and leader in advocacy for children in the community and for social change. Another author has argued for the 7 functions of a general pediatrics program within an academic department (10): teaching at every level; developmental and behavioural pediatrics; preventive pediatrics and epidemiology; community services and child advocacy; administrative leadership; primary and secondary care for children with complex and often chronic problems; and research.

In surgery, a recent survey of the 16 Canadian university-based training program directors alludes to a “rural healthcare crisis” with regard to the paucity of available newly trained general surgeons and the advancing age of those currently in practice (11). Seventy-five percent of those surveyed saw a continuing need for training of general surgeons and a need for the evolution of training guidelines. While community surgery rotations were available at 15 of the 16 programs, only 20% to 25% of trainees took part in such experiences during their residencies, despite the value placed on such rotations by the RCPSC. The survey authors argued for mandatory community surgery rotations during residency and optional general surgery fellowships, as well as a revision of the range of subspecialty exposure needed for community-based general surgery practice. In 1993, the same authors surveyed surgery residents across Canada and found that 19% of residents planned to pursue a standard general surgery career and an additional 12% planned to be “generalist” general surgeons (that is, they would do some subspecialty procedures that would be of particular value in nonurban settings) (12). The likelihood that a resident would select the latter career option declined, however, with each year spent in training. The authors speculate that a lack of community experience during residency and, presumably, the lack both of exposure to appropriate mentors in those settings and of prestige associated with such choices in the academic community may contribute to the declining interest in generalist careers. The residents identified professional collegiality, hospital facility support, recreational opportunities, and educational considerations for their children as important incentives for a generalist career.

In light of these developments among our medical, pediatric, and surgical colleagues, the creation of a general
psychiatry division is both timely and consistent with trends in training. The 4 challenges established at its inception in 1993 involved:

- enhancing the current core (PGY2) year of training in general hospital psychiatry mandated by the RCPSC
- creating “career-track” positions in general psychiatry (where 6 to 12 months are devoted exclusively to advanced training akin to the subspecialization years in internal medicine) for senior residents; creating postresidency fellowship positions with the same clinical and academic opportunities that exist for our psychiatric subspecialties
- providing community-based inpatient and outpatient experiences during residency training beyond the walls of the major teaching hospitals and including underserviced areas
- creating a niche within the university for the academic generalist as a valued clinician, teacher, and researcher, which also means working against an attitudinal and hierarchical dichotomization of research and clinical care—as if we could continue the idea that excellence in each can exist independent of the other.

In reviewing our progress over the last 2 academic years, 3 important changes have been achieved. First, training guidelines for the PGY2 year in general psychiatry have been promulgated. These describe specific educational objectives in terms of knowledge, skills, and attitudes. These pertain not only to the inpatient and outpatient experiences but also to emergency psychiatry. Improved exposure to and training in substance abuse—though still inadequate relative to the scope of the problem—have been added. Residents have been invited to participate with staff in our Provincial Psychiatric Outreach Program, working in inpatient and outpatient settings in Northern Ontario; this has been so successful that there is a waiting list of residents wishing to go on these trips and increasing demand that such exposure be a mandatory part of training. The application of these guidelines to the teaching hospitals has had considerable effect, which may in turn reflect their substance. Clinical teaching units have been dropped as training sites, new mentors have been added, and in vivo supervision of emergency work has become a norm. This latter change has occurred in the larger context of reorganization of emergency psychiatry training resources to provide appropriate settings for achievement of academic goals; this process has been contentious because of service and resource implications for teaching hospitals. Copies of the training guidelines are available from the corresponding author on request.

Second, career-track positions in general psychiatry have been filled at 4 teaching hospitals and have included senior residents involving themselves in inpatient as well as outpatient work—a change from earlier days when inpatient rotations were seen as a junior hazing ritual to be survived in order to graduate to outpatient, office-style practice. These residents have functioned as teaching fellows to junior residents and medical students and have been allowed greater autonomy with regard to supervision. A greater community involvement has also taken place, with career-track residents consulting to hostels, shelters, community agencies, and community home nursing programs. Early feedback from these residents is that they not only enjoy these experiences but plan to continue them postresidency. Several career-track residents have been recruited to fellowship positions in preparation for academic careers.

Third, within the university, faculty in the general psychiatry division have played a prominent role in both education and educational scholarship (innovations in course design and evaluation) as previously described and have made more modest contributions to research. They have been extremely active in undergraduate education, including promotion of the OSCE (observed structured clinical examination) format of student evaluation and provision of both mandatory and elective experiences for medical students. The use of the OSCE format has itself generated data and findings in educational research presented at international meetings. Our first fellow in general psychiatry received peer-reviewed salary support to allow pursuit of his research on psychiatric education and completion of a graduate degree in that area. Continuing education is an important component beyond the clinical service of the Provincial Psychiatric Outreach Program, and there has been an enthusiastic response from mental health professionals in underserviced communities. Faculty have also been involved in course development and teaching of mental health and the law to law students and psychiatry residents in a course offered by the Faculty of Law at the University of Toronto. Further, they have been involved in organization of conferences on emergency psychiatry for community mental health professionals and perspectives on psychotherapy integration. Completed research projects since the inception of the division include a qualitative study of multidisciplinary team functioning on an inpatient unit and the use of televideo technology in providing psychiatric consultation to underserviced areas. Finally, faculty have participated in planning groups at provincial and community levels to improve delivery of services within a mental health system and to contribute to mental health reform in Ontario. Ultimately, however, the success of this division will be reflected in the academic and clinical directions taken by our trainees, the first group of which will complete their residency training in 1997; they will be evaluated with regard to the impact of the training guidelines.

In a university department with so many established academic subspecialties, one may rightly wonder where are the academic foci for general psychiatry. Particular clinical areas such as suicide, however, traverse the boundaries of our matrix and demand critical inquiry. In other regards, the foci of general psychiatry will likely parallel those described earlier for general pediatrics and general internal medicine, that is, clinical epidemiology, ethics, and education.
Members of our division are already making significant academic contributions in these areas, but they need to be expanded and to serve as a magnet for recruitment of residents, fellows, and future faculty.

We hope our response to the 1994 British symposium “Is General Psychiatry Dead?” is evident from this paper. Indeed, it is at an early recovery stage after a long illness of neglect, hoping to connect anew to both the university and the community.

**Clinical Implications**

- General psychiatry may suffer by training neglect.
- Subspecialization may dwarf generalization.
- Training must reflect community need.

**Limitations**

- No systematic program evaluation.

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**References**


**Résumé**

**Objectif** : Décrire la raison d’être, les origines et les buts d’une division académique nouvelle de psychiatrie générale dans un milieu universitaire.

**Méthode** : Tour d’horizon de la littérature, observations et description.

**Résultats** : Deux ans après sa création, la Division de psychiatrie générale de l’Université de Toronto a commencé à atteindre certains de ses buts et à préciser des objectifs particuliers.

**Conclusions** : À une époque marquée par une sous-spécialisation universitaire croissante, le maintien de compétences de base en psychiatrie et la reconnaissance du besoin public continu de psychiatres généralistes doivent être enchâssés dans les programmes de formation universitaire.