informa
healthcare

Current issues in Swedish Psychiatry

The Swedish Psychiatric Association maintains a clear focus on strengthening the Continuous Medical Education for psychiatrists.

During 3 full days, 11–13 March, the second Swedish Psychiatry Conference was held in Gothenburg. The Conference has been further expanded and more comprehensive in comparison to previous Annual meetings, and attracted more than 400 attendants. The organizers were very pleased, though quite exhausted from hosting this very successful event.

Just like last year, it was very encouraging that so many enthusiastic colleagues volunteered in assisting to shape this conference into an important large-scale Continuous Medical Education activity, covering a broad array of topics with a large number of symposia, lectures, courses and workshops. All those who were invited to lecture accepted, and have contributed very constructively by imparting their knowledge to a broader audience.

There is no formal requirement for Continuous Medical Education for specialist physicians in Sweden. It is not mandatory to participate in educational activities. On the contrary, it is the norm for psychiatrists to keep their specialist status over decades with no requisite for further education. The Swedish Psychiatric Association has therefore initiated a discussion with the Swedish Medical Association and the Swedish Society of Medicine requesting a requirement for Continuous Medical Education in order to maintain the right to practice as a psychiatrist.

The Swedish government has shown a great interest in psychiatry, but it remains uncertain whether this has resulted in any substantial improvements in the psychiatric care. New general rules for health insurance, recommending a maximum number of "sick days" for each diagnosis have given rise to some concern. These new rules might have negative consequences for some patients suffering from chronic disorders.

The government has also aimed to strengthen the education of residents to become psychiatrists through the establishment of a new type of course with more focus on theory through home study courses (the so-called METIS—More Education & Theory In Specialisation—project, which is currently being evaluated).

With the aim of measuring work satisfaction, a comprehensive questionnaire was sent out to all psychiatrists by the Swedish Medical Association as well as the central organization for the municipalities. A very interesting finding was that the two groups most satisfied with their job were the forensic psychiatrists and the psychiatrists who were doing clinical research (i.e. including clinical work). Most dissatisfied were the full-time clinicians.

Instead of reiterating that we need more specialists in psychiatry, we need to explore which factors could be relevant for recruiting new psychiatrists, and to discuss how we can stimulate, and increase the interest among doctors to remain in psychiatry.

For child and adolescent psychiatry, the Swedish government has set up a "bonus" system for departments/clinics that can demonstrate that patients get an appointment with a child and adolescent psychiatrist within 30 days of contacting the outpatient unit. This is an important initiative, and the outcome will be monitored closely.

The Swedish National Board of Health and Welfare (SNBHW) is currently producing guidelines on how best to treat psychiatric disorders, The most recent guideline concerns depression and anxiety in children, adults and elderly patients. This document is now being finalized, and suggested treatments are being appraised for recommendation. The document will then be presented at a public hearing before the summer. Information about this project is available under the SNBHW homepage: www.socialstyrelsen.se using the Swedish search words: *Nationella riktlinjer*.

It will be interesting to see to what extent these guidelines are adopted by the average clinician in the everyday clinical world. The initiative as such could appear contradictory to other current strong, and sound directives from the WPA and NIMH advocating "psychiatry for the person". That treatment in psychiatry should be "tailor made" for each patient appears difficult to combine with any kind of adherence to a guideline, unless the guidelines resemble algorithms, taking into account that the patients are heterogeneous with very differing needs. It does indeed seem very natural for most physicians, challenged, as we are, in our ambition to give each patient the best possible treatment, that we individualize our treatment, and continuously monitor our patients

In conjunction with these initiatives, the Swedish Psychiatric Association has strongly advocated an integrative approach where monitoring of the patients' physical health should also be included in the "treatment algorithms", ensuring that patients with psychiatric disorders get the same level of general healthcare as the rest of the population.

DOI: 10.1080/08039480902931189

In addition, as psychiatrists we are often expected to evaluate the latest clinical research, which frequently has its shortcomings (e.g. it can be difficult to address potential aspects of bias in studies). The populations of patients in randomized controlled trials studies are often too selective, and do not reflect our practice, or in naturalistic trials they include too diverse a spectrum to really be useful at a level appropriate to influence decision-making. We simply cannot take clinical research results at face value, but instead need to understand better the limitations of the study design and methodology so that we can interpret the results presented to us. We need to debate the impact of the results openly and, only then apply them, with prudence to our own patients.

To reach the best possible standard of clinical practice in Swedish psychiatry, we should also strengthen clinical research under "real" conditions. We need long-term follow-up naturalistic studies to evaluate the effect of what we are doing (and not doing). Furthermore, there are immense opportunities in contemporary ICT technology that have not been thoroughly explored to improve treatment. One small example of this is Swedish trials showing how administering psychotherapy via the Internet can be user-friendly, easy to administer, and effective.

There are many research areas that deserve more funding and more attention. In Scandinavia, we have unique opportunities for doing long-term clinical research that do not exist in countries like the USA, because of our registries that enable us to follow patients over a long time. Many psychiatric disorders are chronic, cause suffering over many years and carry large costs for both the affected families and society. The development of new options for treatment should be promoted. It is the only way in which we can provide new hope to patients with schizophrenia and other chronic psychiatric disorders, and to their families and carers.

As psychiatrists, we cannot afford to lie back and wait for the pharmaceutical industry to come up with new treatments. As a group (and as individuals) we need to evaluate what we are doing, and expand our knowledge based on research to optimize the treatments that are available. We have tried above to outline some initiatives on how we can ensure this "ongoing Continuous Medical Education". A further way to keep up to date could be to read journals like this regularly, because it gives a good overview about the flow of new ideas in our field with a focus on what is happening in our region of the world.

Christina Spjut
Chairman of the Swedish Psychiatric Association

Jonas Eberhard
Swedish Editor