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EDITORIAL

# A leadership crisis in American psychiatry

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A profound leadership crisis is limiting progress and preventing American psychiatry from reaching its full potential. As recently as January 2000, Dylan Thomas wrote a book review in *Nature* (2000; **403**: 19–20) with the following title: 'Medicine's least respectable branch?' In the text of that article he commented on psychiatry's 'failure to shake off its image as the least respectable branch of medicine.' Is that indeed the case? In the United States a high number of fully symptomatic patients, many of them acutely hallucinating, roam the streets of our cities and we all walk by busy while no assistance or treatment is offered to them. The penal system is now the largest provider of mental health services.

Many academic medical centers outsource clinical psychiatric care, and teaching to affiliated county, state, or federal facilities. Those that have psychiatry within the academic medical center manage a perpetually decreasing number of psychiatric beds and services, which are seen as not offering a high enough profit margin to justify competition with procedurally based specialties for limited and costly inpatient space in the latest generation of newly built, ultramodern academic medical centers. The National Institute of Mental Health Intramural Research Program is going from an apex of over 100 inpatients beds in its golden years to an upcoming nadir of 22 beds in the new clinical research center that is nearing completion. This represents an 80% reduction in capacity of the country's premier clinical research facility for mental health.

In those places where psychiatric patients can still be hospitalized in the main academic medical center, the lengths of stay are far shorter than the time it takes for antipsychotics and antidepressants to exert their therapeutic effects. Therefore, inpatient care is merely a process of acute sedation and rapid discharge, without the possibility of evaluating the therapeutic effects of prescribed psychotropics. This practice severely limits the quality of patient care and teaching, as students and residents undergo training without seeing the onset of therapeutic action and time course of drugs that are widely prescribed. Outpatient settings do not offer the same training capacity to present on a daily basis the course of action of psychotropic medications. Moreover, the drugs we use are all still based on the worn out monoamine hypothesis of depression and dopamine hypothesis of schizophrenia. No drugs with conceptually novel mechanisms of action have been approved by the Food and Drug Administration (FDA), even though psychotropic medications have over the years been the key blockbusters for several of the world's major pharmaceutical companies. In addition, in spite of an enormous amount of research on genetics and genomics, the biological basis of all major psychiatric disorders is still unknown. As our specialty erodes, the silence is deafening. Leadership in psychiatry has not risen to the demanding job of ensuring that psychiatry goes from least to most respectable branch of medicine.

This is particularly regrettable in the light of the positive developments that have the potential to usher in a new era in psychiatry. Since the decade of the brain started over 13 years ago, several billion dollars have been invested in mental health research. The most visible outcome is the spectacular rise of neuroscience, the basic science foundation of psychiatry, as a leading scientific discipline. The last Society of Neuroscience meeting (New Orleans, November 2003) was a stunning success. In all, 65% of the society's membership attended the meeting, presided by Huda Akil. There were over 28 000 participants in total. The superior scientific standing of neuroscience research has led publishing houses to highlight it as they branch out into specialty journals. Those titles include *Nature Neuroscience*, *Nature Reviews Neuroscience*, and Cell Press's *Neuron*. Additionally a very talented and well-trained cadre of physicians is seeking research training in psychiatry.

Clinical psychiatry has the most fascinating phenotypes of all of medicine, including common and complex disorders of gene–environment interactions; the fundamental basic science research that constitutes our foundation is the best of any type of science; we have superb trainees, and our drug targets are the most lucrative of all.

What is the locus of the disconnect between the promise of contemporary neuroscience-based psychiatry and the dismal failure of our academic departments to compete successfully with other specialties to promote clinical care, teaching, and related applied research? Why has the leadership of our field not won the battles for integrating the excitement and promise of science and clinical presentation to the arenas of healthcare delivery, institutional resource allocation, and academic policy? Rather than indulge in editorial speculation, I ask our readers to think about this at length and to share their opinions in an open debate that may lead to reflection, development of new attitudes, and eventual change. Please E-mail me. I will begin this process by suggesting that we need creative new mechanisms specifically designed to groom academic leaders who have the motivation, enthusiasm, and formal working knowledge of state-of-the-art neuroscience and clinical psychiatry, as well as effective administrative skills needed to actively and relentlessly promote from within and from without institutional and societal changes that strengthen the academic, clinical, and public health roles of psychiatry.

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