e-Interview

Susan Benbow

Susan Mary Benbow is an old age psychiatrist and systemic therapist who trained in Manchester. Currently, she is Visiting Professor of Mental Health and Ageing at Staffordshire University and Director of Older Mind Matters. She trained in psychiatry in Manchester and her first consultant job in old age psychiatry was at Manchester Royal Infirmary. Her interests include working with families, teaching and research.

Looking back on your career, what have you learnt and what would you do differently?
I have learnt that what helps one family makes life worse for another: that what one family can take in their stride, another cannot live with, and that my role with a family is to try to help them work out the best way forward, which may not be what I would choose for myself. I think this is something that medical students in particular struggle with. It makes life more interesting but much more complicated.

What has been the highlight of your career?
There have been lots of highlights, some large, some small. I enjoyed my stint as Chair of the Faculty of Old Age Psychiatry and felt I made a contribution to the specialty. Similarly, I enjoyed being NIMHE Fellow and tried to make a difference. As a clinician there are regular smaller highlights when people recover from severe illnesses and pick up their lives again. As a teacher, highlights occur when teaching helps students from different professional backgrounds regain the enthusiasm and passion for their work which they had previously lost.

. . . and the lowlight?
I do not think I recognise 'lowlights' but I may be in denial. I recognise constant struggles and, if there were lowlights in my career, they were when managers imposed ill-considered but fashionable changes to services which had the opposite impact to that allegedly intended – usually despite sensible comments from the people actually working in the service. I must add that I have worked in partnership with some excellent managers in the past, but I fear that partnership between clinicians and managers is currently unfashionable.

The greatest pleasure in life is . . . ?
Windsurfing.

Having been an old age psychiatrist, what are your observations on what makes a happy old age?
The things that make a happy old age are the same things that make for happy young and middle age – families, relationships, somewhere congenial to live, enough money to get by, and the opportunity to continue doing things that you enjoy.

Should wards be single or mixed gender?
Life is mixed gender. We are going round in circles with this. Mixed wards were once an innovation – now single-gender wards are. I think the main issues here are dignity, privacy and safety: if we can make sure people are able to maintain their dignity and can have the privacy they wish while remaining safe, then the fact that a ward is mixed gender is irrelevant. On the other hand, a single-gender ward does not automatically ensure either dignity or privacy.

Why don't medical students aspire to be psychiatrists?
Medical students do aspire to be psychiatrists but I think the training conspires to deter them, by devaluing compassion and empathy in a blinkered quest for so-called evidence-based medicine. Relationships with patients and families are seen as an issue peculiar to mental health but in fact are part of all chronic disease management. Uncertainty is more upfront in psychiatry and more uncomfortable. In reality, the whole of medicine would benefit from more attention to the relationship between doctor and patient and the art, as well as the science, of medicine.

Where is psychiatry going?
The short answer is round and round in circles. The longer answer is that I think it needs to go back to being a medical specialty with a scientific base, to stop being ashamed of being part of medicine, and confess that it aims to treat mental illness, not to tinker with the lives of the discontented.

What is the most promising opportunity facing the profession?
Why are we not celebrating the fact that people are living longer? That in itself is an opportunity for old age psychiatrists. The increase in the population of older people means that the mental health challenges of later life cannot be ignored or assigned to Cinderella services. Older people could potentially become politically powerful and how would that shift National Health Service priorities? We have anti-Alzheimer drug treatments in regular clinical use and the next generation of drugs promises more.

What is the greatest threat?
I think the role of highly skilled professionals in working with older adults is threatened by a fear that, with the shifting demography of the population, the nation cannot afford to provide high-quality care for older people who develop dementias. So instead of recognising dementias as neurological illnesses (which they are) they risk becoming social problems, which means that people with dementia and their families do not appear to need access to health staff and healthcare, thereby saving taxpayers money. Yet those same taxpayers (us) are the people who are going to need good services in the future. If we sell people with dementia and their families short, we sell ourselves short.

What conflict of interest do you encounter most often?
Personally, the biggest conflict of interest is when it is windy during the week and I have commitments incompatible with getting out on the water windsurfing. In practice, the common conflict is between the needs of patients and other family members.

Is there any role for doctors in euthanasia?
No. I believe that non-malfeasance in medicine should be preserved at all costs. Introducing euthanasia would give doctors competing interests in patients who want to hang on to life despite pain and suffering: both their own and their family's.

Lucy Watkin

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