
**Our Time is Now | Part I: What If We Train All General Psychiatrists to be General Psychiatrists?**

Training physicians to be psychiatrists is a daunting task. We are the medical specialty which treats brain conditions that manifest with behavioral or mental symptoms. Since psychiatric illnesses exist at the intersection of neuroscience, culture, and psychology, a general psychiatrist must be trained in a broad range of foundational intellectual disciplines. They must learn a similarly broad range of evidence-based treatments – medications, brain stimulation, targeted and structured social support, cognitive remediation, individual and family psychotherapy, and more. In the face of this breadth and depth of material, we inevitably make choices in what conditions, types of patients, treatment settings, and interventions to prioritize in training.

Several different forces may drive the creation of subspecialties. One is when the complexity of clinical area is so great that additional training is deemed necessary. Another, however, may be the need to legitimize the study and treatment of a marginalized cohort, such as persons with addiction and older persons. Unfortunately, there can also be unintended effects of subspecialty creation, including a decrease in the sense of 'ownership' of subspecialty patients by general psychiatrists.

Today we face challenges that call for revisiting the boundaries between our core specialty and subspecialties. Addiction psychiatry, geriatric psychiatry, and child/adolescent psychiatry encompass three of the most urgent areas of population mental health need. First, the ageing of the Boomer generation means the proportion of our population that is geriatric will continue to expand sharply and some evidence indicates this generation is at particularly high risk of psychiatric illness. Second, the opioid epidemic – already far from controlled – has accelerated in the past several years with the rapid spread of fentanyl across the entire country. Third, youth mental health was already a growing crisis before the pandemic and evidence suggests that COVID sharply worsened the isolation and suicidality among adolescents.

Are we prepared to meet these needs? The good news is that general psychiatry programs have been growing and this has been matched by an upswing in numbers of US medical graduates aspiring to psychiatry. The bad news is that this has not created momentum that carries over to the subspecialties, where recruitment remains difficult and many training spots are unfilled. However, the problem may be more fundamental. Even if we succeeded in filling all three subspecialty slots, this would not provide nearly enough workforce bandwidth to meet the present and looming crises.

In this talk I will describe the nature of the challenges we face in preparing psychiatrists to respond to population mental health needs. I will argue that we need to substantially change how our core specialty defines its priorities to better encompass the public mental health epidemics we are facing. I will suggest that though each subspecialty encompasses complex cases beyond the scope of general psychiatry training, they also include relatively routine presentations that may be within the reach of all our graduates. We will then explore what it would take to prepare all general psychiatrists – both in terms of skill sets and in terms of professional identity – to rise to the current occasion.