Fellowship of the College: Notice to Fellows

The attention of Fellows is drawn to Section IV of the Bye-laws:

'1. A Member with not less than five years of seniority as such shall be eligible for election to Fellowship; provided that a Foundation Member may at his option require that such a period of seniority shall be deemed to have commenced upon the date upon which he first held consultant status in the National Health Service, or other post or status accepted by the Court of Electors as being equivalent thereto.

'2. Any two Fellows may nominate any Member of requisite seniority for election to the Fellowship. Nominations, with supporting evidence, shall be considered by a Sub-Committee of the Court of Electors. The names of Members recommended by the Sub-Committee for election to the Fellowship shall be submitted to the Court of Electors, which may elect such Members or any of them to the Fellowship by not less than a two-thirds majority of those present and voting. In exercising such power the Court of Electors shall pay particular attention to qualifications and professional standing, to appointments held, and to contributions to research and to the literature and the practice of psychiatry'.

The Court of Electors has resolved that Fellows of the College should be reminded of their duty to put forward their nominations for the Fellowship. Normally nominations will be invited for 1 December each year, and considered by the Court of Electors in January.

Nominations should be proposed and seconded, and accompanied by a short statement of the candidates' worthiness. Subsequently, the Members concerned will be informed that their names have been put forward for consideration by the Court of Electors, and they will each be invited to submit a *curriculum vitae* to help the Court in its deliberations.

K. RAWNSLEY,
Dean.

PSYCHOGERIATRIC SERVICES

By KLAUS BERGMANN

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It will be remembered that the Department of Health and Social Security's Memorandum on the future of hospital services for the mentally ill specifically excluded all consideration of the problems of psychogeriatric care, and that this prompted the National Association for Mental Health to produce their 'Mind Report' No. 6, entitled 'Now tell us how to solve the psychogeriatric problem of the psychiatric hospitals'.* Fourteen questions were asked, covering divers areas such as the quality of information available for assessing the psychogeriatric problem, what the future admission policies were to be, what were acceptable standards of care, what practical alternatives existed to psychiatric hospital care for the elderly mentally impaired and what were the answers to the problems of provision and integration of local authority developments within the community.

In October 1972, the D.H.S.S. produced its Memorandum on 'Services for Mental Illness Related to Old Age', and this was accompanied by a Circular (HM72/71) commending the Memorandum. The N.A.M.H.'s reaction is 'Mind Report No. 9: Psychogeriatric Services—Questions Answered?' published in February 1973.

This report examines answers deduced from the D.H.S.S. memorandum. Its conclusions are uniformly unfavourable. Five questions are considered to be totally unanswered, and no answer given is accepted as satisfactory. The most severe criticism is levelled at the failure to co-ordinate local authority and National Health Service planning. The failure to lay down satisfactory standards of staffing and care for those elderly patients requiring hospital-type treatment or care on account of their mental state is also a notable omission, and the Report compares this state of affairs with the much more definitive criteria that have been applied to 'the better services for the mentally handicapped'.

Mind Report No. 9 has been a valuable exercise, and in many ways the forebodings felt by the authors must be shared by all who are concerned with the care of the elderly. Perhaps it might be worthwhile to pause and wonder whether the D.H.S.S. is too easy a scapegoat. Psychiatrists, geriatricians and social workers can all point the finger of scorn at the

* An article by Dr. J. A. Whitehead commenting on this Report appeared in *News and Notes* for August 1972.

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administrators, and forget that their own attitudes may also have contributed to the present unsatisfactory situation.

An example of this could be taken in the rather tremulous statement by the D.H.S.S. on page 6, para. 23, which states 'experience in some areas has shown it may be advantageous to appoint a psychiatrist with special responsibilities for the psychiatric services for the aged'. Behind this unexceptionable and quite unhelpful statement lies the controversy within the psychiatric profession which has made so many psychiatrists deny their responsibility for the care of patients with organic brain disease by the simple sleight of hand trick of saying 'as this is a physical disease, it is within the realm of the geriatrician' rather than taking the more practical view that the psychiatrist is involved with disturbances of emotion and behaviour regardless of the aetiology. Some of this negative attitude is also reflected in the Mind Report which says 'have controls been suggested on the intake of patients over 65 who are mildly deteriorated . . .?' (i.e. those patients likely to live for more than two years). It seems to suggest a positive virtue in keeping out active, fit, mildly deteriorated patients from psychiatric care. Unfortunately, the mildly deteriorated, fit, active, elderly often have symptomatic psychoses or emotional disturbance and may well require a fair period of psychiatric care, control and treatment. Moreover, the patient who is likely to die very rapidly is most often found on a medical geriatric ward.

It is to be welcomed that the D.H.S.S. has at last recognized a class of patient everyone else has known about for many years! The 'person with severe dementia but not suffering from other significant disease or illness' has arrived. In fact, he is here to stay, but only in 2.5 to 3 beds per thousand of the population over 65, and only in a community hospital, whatever that may be. One suspects the worst. It is clear that the community hospital is not the gleaming new district general hospital, nor yet the recently vacated psychiatric hospital. Is it perhaps the old workhouse? The half-empty tuberculosis hospital? The deserted fever hospital, or some other peripherally situated relic? Land values are high, and the sites where these places exist may well be useful and situated near large residential areas of the suburban type. And how these are to be converted, equipped, staffed and integrated into the system of progressive patient care based on the general hospital unit is not at all clear. The easy rationalization that nurses are often more readily recruited to peripheral hospitals ignores the fact that the nurses in charge need to be psychiatrically trained and gain experience in dealing with emotional and behavioural upset.

Both the D.H.S.S. and Mind Report No. 9 take a far too narrow view of the crisis in local authority care. In many areas of the country the whole concept of a residential home is being brought into question. Sheltered housing, home help, meals on wheels, the health visitor and social work supervision and a multiplicity of voluntary services have meant that in many areas already very few fit but socially disadvantaged people go into residential care. In fact, residential care has changed its character, and residential homes are increasingly hostels for the infirm, both mentally and/or physically. Present standards of provision, therefore, are already strained to the limit, and the resources required to meet the extra load on a system already requiring improvement in its own right are not recognized. Perhaps also it is too little recognized that the person with 'mild dementia but not suffering from other significant physical disease or illness' is not in a stable state: his only path is downhill, and an intercurrent 'flu epidemic may well create a breakdown in the ability of the staff and other residents to cope with disturbed behaviour of the so-called 'person with mild dementia'.

To restate the basic problem: this is that about 13 per cent of the population of Great Britain, which will rise to about 16 per cent by the 1980s, contains a substantial number of people who are economically and socially deprived. These people suffer more frequently from progressive brain disease. Their functional psychiatric disorder, though as severe and as prevalent as any found in the rest of the community, is untreated and largely undetected and they are more liable to severe physical ill-health. What psychiatric services would best meet their needs, and how one could design such a service, are the questions to be asked. Instead of this one is left with the feeling that somehow the deteriorated patients have to be got out of the way and that the better ones can be squashed into the general hospital psychiatric units. Has anyone considered that these units may not be good enough to cope with the needs of elderly patients with functional disorder and physical disability?

The D.H.S.S., Mind Report 9, and many psychiatrists accept uncritically the statement that patients with functional psychiatric disorders can be readily managed in the district general hospital psychiatric unit setting. This presupposes that dependency patterns, remittent trends in the natural history, special associations of affective disorder with certain physical conditions and the special needs for after-care and social management are identical with those of younger patients. Sufficient accepted and published data exist to prove this assumption false. Even patterns of initial consultation and ascertainment differ

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substantially between the aged with functional disorder and their younger fellow-sufferers. Nevertheless one must welcome both the D.H.S.S. effort to define groups of patients requiring care and to commit itself to specific, but we hope not definitive, suggestions, and also the concern of Mind Report No. 9, to raise important and sometimes ignored questions of detail.

Perhaps it may be permitted to finish this review on an economic note. On the face of it the closure or reduction of psychiatric hospital care would represent a transfer of a large economic burden from the central government's exchequer to that of a large number of highly varied local authorities. We are assured that extra finance to allow for new provisions will be granted. But if such finance merely amounts to giving the local authorities permission to borrow more money which they ultimately have to repay and on which they pay interest at all times one may have cause to doubt whether they will all avail themselves eagerly of this privilege.

PROBLEMS OF RECRUITMENT INTO GENERAL PSYCHIATRY

By Gerald Russell

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From 1967 to 1970 there occurred a sharp decline in the number of British trainee psychiatrists (1). In 1967 there were 237 British-born or Irish-born registrars training in adult psychiatry in England and Wales; by 1970 this number had fallen to 165. Fortunately, more recent figures show that this downward trend has become arrested: in 1971 the number of British-born and Irish-born registrars was 187. There has not been an absolute reduction in the numbers of junior psychiatric staff because the decline in recruitment of 'home-born' psychiatrists has been offset by an influx of doctors from overseas. In 1966, 41 per cent of psychiatric registrars in England and Wales were born overseas; in 1971 this proportion was 62 per cent.

The reduced appeal of psychiatry in this country may appear surprising. It has happened at a time when psychiatry has featured more prominently in the undergraduate medical curriculum, and when opportunities for post-graduate education are improving. The last few years have also seen therapeutic advances in psychiatry: serious illnesses yield more readily to drugs, fewer patients become institutionalized, psychiatric care is reaching out beyond the walls of hospitals into the community. More psychiatrists are practising in general hospitals, under conditions they find more congenial than in mental hospitals. Thus it is difficult to be certain why the recruitment of British doctors into psychiatry has declined. Two part-explanations suggest themselves. The first lies in the excessive clinical burden imposed on psychiatrists whose prime professional satisfaction is derived from unhurried personal contact with their patients. The second stems from the discouragement given to potential recruits by the Department of Health and Social Security, whose message has been that career prospects in psychiatry are bleak. These two factors will be examined further.

There is evidence that from 1949 to 1967 there was a considerable rise in the use of psychiatric services (2). The increase in the psychiatric services was twice as much in the in-patient sector and three times as much when measured by the attendance of out-patients. This growth was not matched by any comparable increase in psychiatric manpower. Every practising psychiatrist is painfully aware of the excessive demands on his time which prevent him from assessing and treating his patients adequately. The large number of his chronically ill patients serve as a constant reminder of the consequences of past neglect leading to institutional dependence.

This experience makes statistics superfluous, but for the disbelievers it may be necessary to equate data representing psychiatric morbidity with the psychiatric man-hours available. Such an analysis has revealed that most psychiatrists would have to work full out during the whole of their working week simply to give sufficient time to their out-patients and in-patients. This would still exclude essential clinical activities such as domiciliary visits, consultations on patients referred by colleagues from general hospitals, psychotherapy and psychiatric reports for the courts (3). Because such demands cannot be side-stepped, and because teaching, research and administration also make heavy inroads into the psychiatrist's time-table, he has little choice but to take short cuts in his daily clinical rounds. It is especially the chronically ill and the elderly patients who are given short measure. The tip of this iceberg of patient neglect has, in recent years,

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