Brit. J. Psychiat. (1972), 120, 333–9

The Recruitment of Psychiatrists

By GERALD RUSSELL

The Recruitment of Psychiatrists

Every teacher of psychiatry bears a dual responsibility. Not only must he inculcate the essential principles of his subject into medical students, irrespective of their eventual choice of career within medicine, but he must also help recruit into psychiatry a sufficient number of doctors to develop the psychiatric services of tomorrow. Moreover, the quality and personal attributes of these recruits must be such as to do credit to the profession.

The psychiatrist who adopts the role of the proselytizer must try to determine the demand for training psychiatrists. In his daily clinical experience he will encounter numerous patients whose disability is prolonged, possibly to the extent of remaining in hospital for years, because he simply cannot find the time to give them the care demanded by the nature of their illness. Or he may be asked to see a child whose educational backwardness or acts of delinquency demand several hours for their accurate assessment and their effective treatment. Seldom can he do justice to these legitimate demands on his time. Shortages of psychiatric manpower have been claimed in every sub-specialty of the subject (child psychiatry, mental subnormality, forensic psychiatry and psychotherapy), and are also acutely felt in academic departments (R.M.P.A.-A.S.M.E. Conference, 1970). Moreover, the focal point of the psychiatrist's work has been deflected from the traditional psychiatric hospital to out-patient departments, day and general hospitals. There might have been a fleeting hope some years ago that the progressive closure of psychiatric beds signified that the work load was being shifted from hospitals to the community, from the medical man to the social worker. In reality, the policy of discharging patients into the community shows every indication of leading to an increase in medical manpower needs. In spite of an expansion of the psychiatric services in recent years, there remains a wide gap between the numbers of psychiatrists required to tackle these tasks and the number who are available.

The problem must be viewed against the background of a general shortage of doctors in Britain and some gloomy prognostications by the Royal Commission on Medical Education (1966–1968): it was predicted that there would accrue a cumulative shortage of 10,000 doctors over the ten-year period 1966–1976. To some extent, this deficiency arose from recommendations of an earlier enquiry (Willink Committee, 1957) which led to a drastic reduction in medical graduates from about 2,100 per annum in 1957 to only 1,500 per annum in 1964. Among additional reasons given by the Royal Commission for the deficiency were the increasing size of the population of Great Britain, the rising standards of medical practice expected by the public and the greater expectation by doctors to have time for study and relaxation. Contrary to usual belief there has not been, on balance, any net loss of doctors from the country through migration, losses having been more than offset by increasing numbers of overseas doctors coming to Britain. This shortage of doctors will be felt for a number of years in all specialties and particularly in general practice. Thus it is easier to understand the reasons underlying the policy of the Department of Health and Social Security to apply a brake to the expansion of much-needed psychiatric posts, as this might lead to the depletion of other kinds of health services.

When faced with such a competition between psychiatric and other health services, it is reasonable to ask for the results of operational studies into areas of shortage regarding the mental health services. Thus, Last (1970) requested that statistics should be collected on psychiatric morbidity, the frequency of contact between patients and psychiatrists, the length of

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waiting lists for psychiatric treatment, etc. In some of these areas, such as the large numbers of relatively untreated psychiatric problems in general practice, there is a large amount of information (Shepherd *et al.*, 1966). In others, only impressions exist. In the long run the problem of correcting deficiencies in the health services will remain a financial one related to the proportion of the national income which is spent on such services. Given time, more doctors and psychiatrists can be educated and trained provided that the country demands improved medical care.

'As the prosperity of a population increases, there is pressure for a greater proportion of its income to be spent on less immediate medical needs. The weight of attention moves from death to illness, from the treatment of disease to the promotion of health . . . Psychiatric services are extended.' (Para. 335, Roy. Comm. Med. Educ., 1968.) Thus the future demand for psychiatrists in this country will be dictated by economic and social progress, and by public opinion. Sometimes an isolated scandal revealing the pitiable plight of psychiatric patients (Farleigh Inquiry, 1971) serves to awaken the dormant public conscience.

At the R.M.P.A.-A.S.M.E. Conference held at the Institute of Psychiatry in 1969, Kilgour (1970) expressed the view of the Department of Health and Social Security that too many psychiatrists were being trained for general psychiatry. The scene in 1971 may have become illumined by a faint ray of light which was invisible two years ago; it now appears that the Department concedes that there is a need to attract more British trainees into psychiatry.

Career Opportunities in Psychiatry in Great Britain

The preceding account has dwelt on factors, such as the availability of doctors and the size of the patient population, which influence the need for psychiatrists. Another factor which should be taken into account is that of career prospects for the student or doctor who chooses to specialize in psychiatry.

The observations that follow are based on data made available by the Department of Health and Social Security (the Department henceforth) and by Dr. J. L. Kilgour. Since 1966 the Department have published each year, in the *British Medical Journal* and the *Lancet*, tables giving details of medical staffing within the National Health Service in England and Wales. Scotland has been included only since 1967. In this paper, only questions pertaining to England and Wales will be discussed.

These 'league tables' are an attempt to guide the junior doctor to those sections of medical practice which are undermanned and which therefore carry a greater surety of eventual promotion. Such career prospects are indicated by the number of stars awarded for each specialty. Since 1966 adult psychiatry has never earned any stars, though its sub-specialties of mental subnormality and child psychiatry have regularly been awarded several.

The Department estimates the career prospects in a given specialty from a compound of three factors:

(i) the number of consultant vacancies arising from death and retirement;

(ii) the number of junior medical staff in posts and competing with each other for promotion;

(iii) the number of new consultant posts created.

Fig. 1 shows the number of British and Irish-born psychiatric trainees and the number of consultant vacancies for 1967. It is taken from the proceedings of the 1969 Conference on Postgraduate Psychiatric Education (Kilgour, 1970). It shows that in 1967 there were 126 British or Irish-born registrars competing for about 55 senior registrar vacancies; the 55 senior registrars in turn vied with each other for 50 consultant vacancies, a rather more satisfactory matching. Dr. Kilgour's thesis, hardly challenged at the Conference, was that a gross excess of trainees was being recruited into psychiatry and that they would get stuck in the bottleneck of the scarce senior registrar posts. He added that efforts should be made to deflect the excess registrars into child psychiatry and mental subnormality posts, where unfilled vacancies exist both at senior registrar and consultant level. Furthermore, he attributed part of the medical brain-drain to the failure of young doctors to achieve promotion. Shore concurs with this view in *Health Trends* (1970), a

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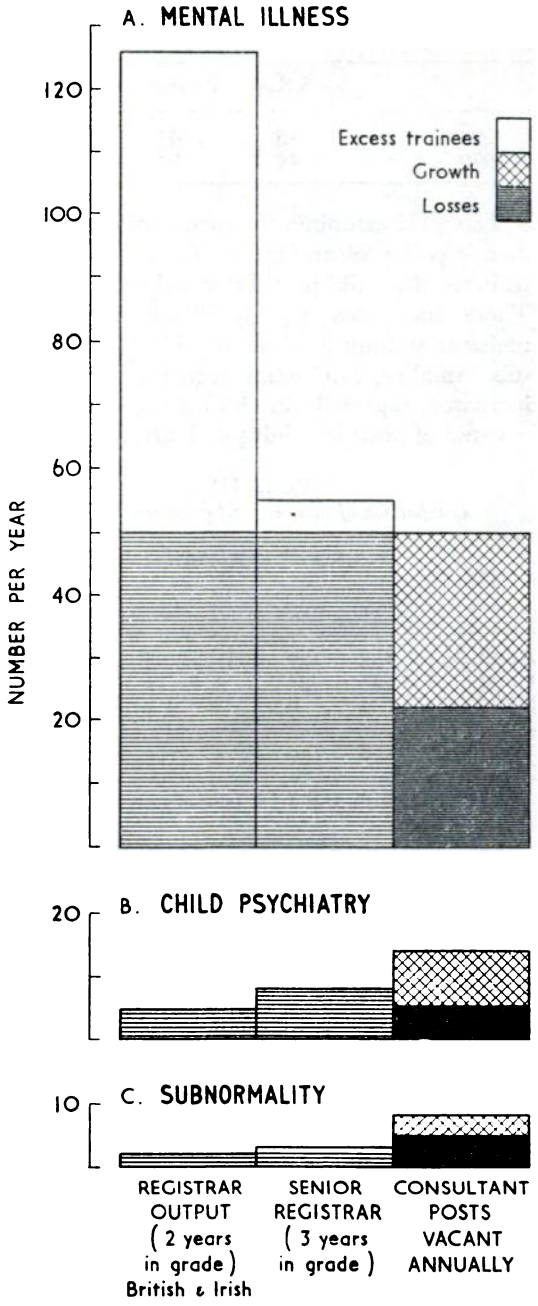


FIG. 1.

Number of trainees in Psychiatry and consultant vacancies available for them (1967). The histograms show that whereas there is a shortage of trainees to fill vacancies in Child Psychiatry and Mental Subnormality, there is a large surplus of trainees in Adult Psychiatry.

publication issued by the Department. There is evidence in support of the view that medical emigration is indeed fostered by failure to advance, at least in the case of surgical registrars (Riddell and Elliott, 1970). Evidence of this kind is not available for psychiatric registrars, but it should be sought; the survey of Maudsley Hospital registrars (Davies and Stein, 1963) suggested that in this admittedly highly selected group emigration of doctors was considerably less. The Department has virtually stopped expanding registrar and senior registrar posts in adult psychiatry. Their reasons for doing this should be examined further.

Fig. 2 shows that since 1965 there has been a steady increase in the number of consultant psychiatrists, including those in child psychiatry and subnormality. In contrast, the recruitment of British and Irish-born trainee psychiatrists, particularly registrars, has declined.

Table I shows the changes over the past four years in psychiatric staffing at consultant and junior levels. The mean annual increase in consultant posts has been 3·9 per cent. There has also been an overall increase in the number

TABLE I

Growth of consultant and junior psychiatric staff (S.R.s + Registrars + S.H.O.s)

	Consultants	Total junior staff	British junior staff
1966	969	801	509
1970	1,120	941	435
% increase ..	+3·9	+4·4	−3·6

of junior psychiatric posts of 4·4 per cent per annum, but this is entirely due to an influx of doctors from overseas at the rate of 18·3 per cent per annum. In contrast the number of British or Irish-born junior psychiatrists has declined by 3·6 per cent per annum, the sharpest decline being at registrar level, and amounting to 9·1 per cent per annum over the last three years. If one examines only the number of registrar posts in adult psychiatry, a precipitate fall of 10·1 per cent per annum is revealed (Fig. 3).

Table II provides further information about

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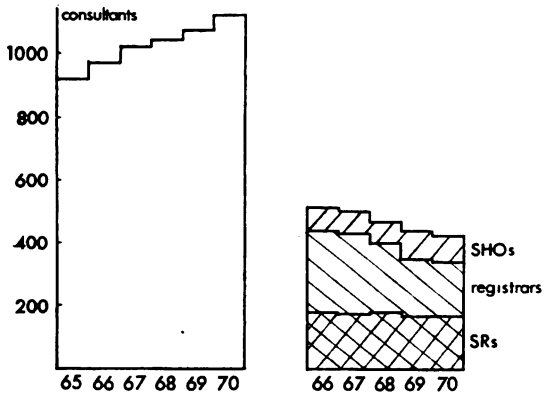


FIG. 2.

'Growth' of consultant and junior psychiatric staff (British and Irish) from 1965 to 1970.

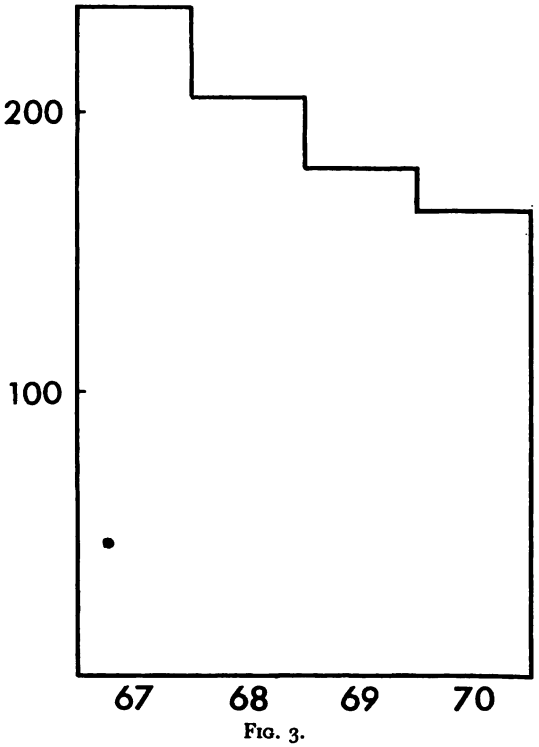


FIG. 3.

No. of registrars in adult psychiatry 1967-1970.

the impact on staffing of overseas doctors. There has been a significant increase of overseas-born doctors among psychiatric trainees from 1966 to 1970, especially at registrar level, from 41 per cent in 1966 to 64 per cent in 1970.

TABLE II

% Psychiatric trainees from overseas

	S.R.s	Registrars	S.H.O.s
1966	15	41	54
1970	24	64	60

Table III examines the success of the Department's policy of attempting to lure psychiatric trainees into child psychiatry and subnormality. There has been no significant increase of registrar staffing in child psychiatry or mental subnormality, but senior registrar staffing has increased, especially in child psychiatry, at the expense of posts in adult psychiatry.

TABLE III

Comparison of numbers of psychiatric trainees

	S.R.s		Registrars		S.H.O.s	
	1967	1970	1967	1970	1967	1970
Adult ..	153	130	237	165	74	80
Child ..	21	31	9	11	0	0
S.N. ..	4	8	6	7	2	3
Total ..	178	170	252	183	76	83

(Only British and Irish trainees are shown)

The Department's policy on recruitment into psychiatry can now be re-examined. Fig. 4 brings Dr. Kilgour's histogram on medical staffing up to date and allows a comparison to be made between 1967, 1969 and 1970. In only three years the number of British and Irish-born psychiatric registrars finishing their training in the registrar grade has dropped sharply from 126 to 82 per annum. This may please those who fear that the bottleneck at the senior registrar level is responsible for professional frustration and emigration. However, it is not so much the absolute level of these somewhat uncertain numbers that matters but their trend. Such a fall in the recruitment of British doctors into adult psychiatry must be a cause for great concern lest it continues unchecked.

CONCLUSIONS REGARDING RECRUITMENT INTO PSYCHIATRY

The Department's concern in 1967 for the imbalance between registrar output and senior

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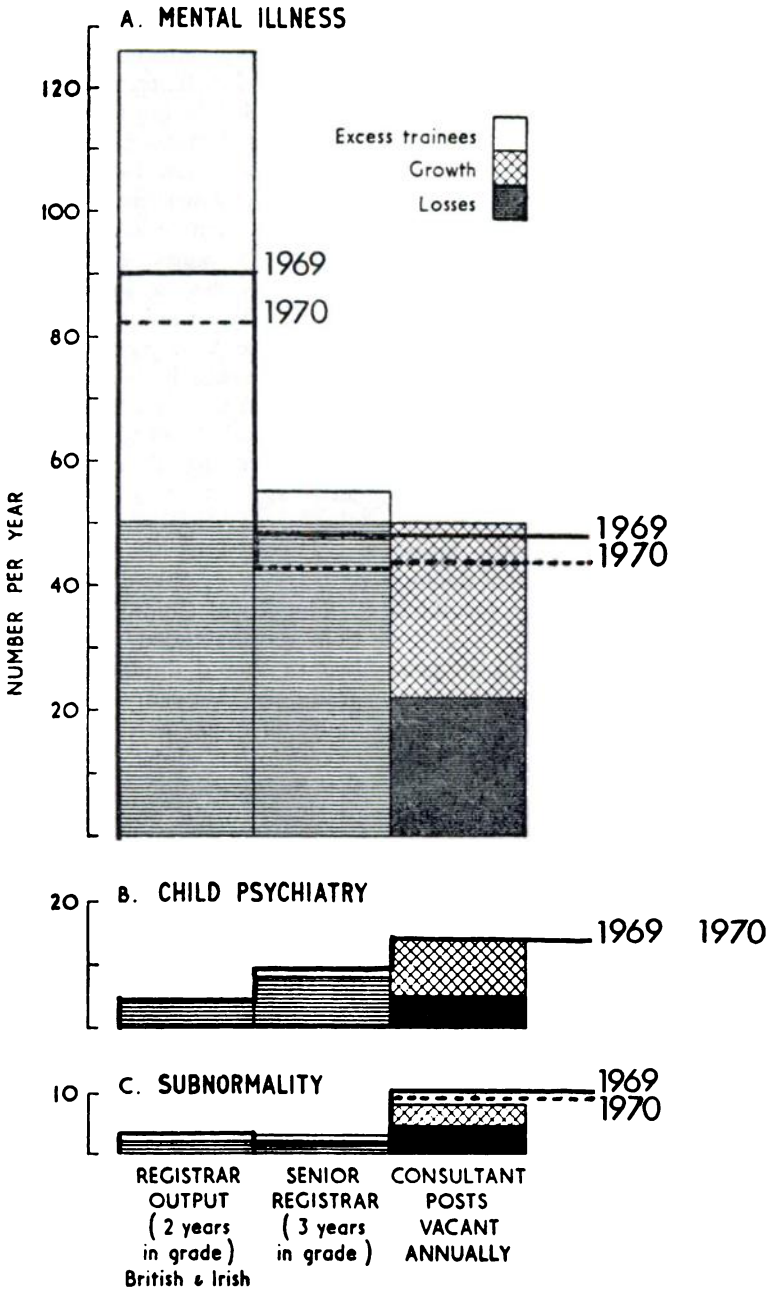


FIG. 4.

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registrar and consultant vacancies, may then have been justified. On the other hand, by blocking the expansion of training posts in adult psychiatry, the Department may be responsible for the falling recruitment of British and Irish-born doctors into the specialty, and this is a heavy responsibility to bear.

The proportion of all young doctors who were training in psychiatry was also considered by Kilgour (1970). He stated that 4·2 per cent of doctors at present working in National Health Service career grades are choosing psychiatry. The Department say they may allow an increase to nearer 5 per cent by 1979. Last (1970) showed, however, that when asked only 4·2 per cent of young doctors said that they would take up psychiatry as their chosen career. This percentage is so close to the Department's estimate that it allows no margin for wastage. There are, moreover, other imponderables which make it difficult to predict the future from these data; for example, the loss of doctors to the universities, the 'wastage' due to matrimony, and so on.

It is now clear that the bottleneck in promotion for psychiatric registrars is fast disappearing and there is falling recruitment of British doctors into adult psychiatry, and this probably means a reduction in their quality.

The Godber Report on the Responsibilities of the Consultant Grade (1969) gave rise to anxiety lest consultants were to lose some of the assistance they received from junior staff. However, the reassurance was given by representatives of the Department to the Joint Consultants Committee (B.M.A., 1969) that the ratio of 1·3 training posts to each permanent consultant post would be maintained at least until 1978. It is to be hoped that the ratio of training to consultant posts in psychiatry should be of at least the same order of magnitude. Moreover, in the same report it was foreseen that the annual growth rate of junior staff in the hospital services would only be reduced from 3 per cent to 2·5 per cent. If the *total* junior psychiatric staff is considered, the growth rate is at least this figure (4·4 per cent per annum from 1966 to 1970). This has been achieved however, only by recruiting overseas doctors into the junior grades of registrar and senior house officer.

In short, it seems clear that the Department's policy of discouraging adult psychiatry as a career choice for the British graduate has been dangerously effective and should now be reversed. Psychiatry has been severely hit and has been left perilously undermanned by British doctors at the junior level. Because doctors from overseas are now filling the breach, their departure, which is now encouraged by some, is likely to have serious consequences. The Department's policy over recent years not to create any new senior registrar posts can only worsen the situation and act as further discouragement for potential recruits into psychiatry. This will have serious consequences at a time when further demands are being made on the mental health services, especially with regard to the development of extra-mural services.

Impact on Undergraduate Education and Recruitment

The Royal Commission on Medical Education recommended that medical schools in Britain should double their annual output of graduates in twenty years to reach a target figure of 4,500 per annum in 1990–94. Brief reference has already been made to the view that a reasonable level of recruitment into psychiatry would be represented by 4·2 to 5 per cent of medical graduates each year. This figure stands in contrast with the recruiting aims of at least some American medical schools which aim at a 10 per cent entry into the specialty (Kolb, 1970). It would seem therefore that three questions need to be asked:

1. What is the optimum level of recruitment of medical graduates into psychiatry?

2. How can this optimum recruitment be achieved through the use of educational methods?

3. At what stage of the medical student's or doctor's training should specialization be encouraged?

The answer to the first question is uncertain and further research is urgently needed, but it is clear that the present downward trend in the recruitment of psychiatrists from British Universities must be reversed. In order to improve recruitment the Department of Health and

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Social Security will need to adopt more positive policies towards the career structure of psychiatrists and the number of training posts available. These have been limited for far too long. As important, however, will be the educational programmes developed in our medical schools which should now aim more directly at inducing medical students to choose psychiatry as a career.

The last question is under scrutiny in a number of medical schools in the U.S.A., including Yale (Lidz and Edelson, 1970), where students are encouraged to select a special programme during the second half of their medical education. The emphasis is on 'elective tracks' prepared by various departments or inter-departmental committees. Even though few British observers of the American scene would necessarily accept a move towards 'semi-autonomous schools of psychiatry', as forecast by Professor Lidz, there is much to be said for assisting students in selecting their future careers at an earlier stage than obtains at present, and providing potential recruits to psychiatry with opportunities for additional psychiatric training within the limits of the medical curriculum and the availability of elective periods.

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A synopsis of this paper was published in the February 1972 *Journal*.

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(*Received 26 October 1971*)

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