MANPOWER PROBLEMS IN THE PROVINCES

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Recent disputes in the N.H.S. are highlighting a number of problems which have been swept under various carpets of indifference, denial or muddle for a long time. One of these is the number and quality of recruits coming into psychiatry and completing their training. Like almost everything else in Britain, it gets worse as you go further from the London and the South-East area—at least until Hadrian's Wall is reached. And in this, as in many other respects, psychiatry seems to illustrate the inherent difficulties of the N.H.S. in a particularly striking way.

If one looks at these questions backwards over some time, present conditions become rather more intelligible. In 1948, psychiatrists were mostly the superintendents and assistant medical officers of mental hospitals; it would not be exaggerating to say that they tended not to be the cream of the medical profession (though of course, there were honourable exceptions). Otherwise, little more than a handful of psychiatrists existed in general hospitals and academic units; most of them liked to give the impression that they were really physicians. This was the far from promising basis on which the structure of a natural specialty had to be created—aimed to be comparable in standards and size with the older established ones such as medicine and surgery.

When the 25th birthday of the N.H.S. was reached last year, however, it was perhaps surprising how much progress had been made. The authoritarian hierarchies of the mental hospitals had all but disappeared (except in Scotland); a College existed to set academic standards and organize training; a substantial number of consultants were in post, together with a reasonable number of junior staff. In that case, why the present discontents?

Basically, because the numbers of doctors currently in each training grade, when added up, do not produce anything like the right sum for present or future needs, while the proportions of overseas graduates and of those without a serious personal commitment to psychiatry are far too high. There is also a long way to go before training facilities throughout the country reach even a minimally acceptable standard; the fact, for instance, that many psychiatrists complete their qualifications without any systematic instruction or experience in psychotherapy was emphasized in a recent MIND Report (1). The public has been led to expect a steadily improving standard of psychiatric practice in all areas; this means basically more consultants, particularly since the Medical Assistant grade is being steadily phased out as existing incumbents leave the service. However, present trainees simply cannot provide the number of fully qualified specialists needed to cover deaths and retirements on the one hand and a moderate degree of expansion on the other. In that situation, regional differences in vacancies will continue to follow the familiar pattern of N.H.S. inequalities (2). It can also be assumed that the newer sub-specialties, such as forensic or adolescent psychiatry, will have even more than their share of difficulty in recruitment (3).

Like the Treasury, the D.H.S.S. has a tendency to over-react to trends, so that the compensatory swings have alarming effects. (It should be a familiar situation to psychiatrists). At the end of World War II, a large number of doctors left the services, keen to take up specialist posts in the new N.H.S. However, a combination of inadequate financing and professional restrictive practices prevented a large proportion of them from reaching consultant status.

Many eventually emigrated (and we will feel their loss even more bitterly as time goes on), but psychiatry benefited temporarily, since a number of doctors who found their way completely blocked in medicine and neurology switched to a specialty where opportunities were then rather better. But this is a bonus which will not occur again. When the Guillebaud Committee reported in 1957 on the imbalance between doctors and posts, it did not suggest that money should be found to employ more specialists, but that the number of entrants to medical schools should be greatly reduced.

This was in fact done, with quite indecent haste, and its effect, together with that of accelerating emigration—which successive Ministers of Health simply denied—would have brought the N.H.S. to a complete standstill within a few years.

That this did not happen was due to the largely fortuitous fact that a greatly increased output of medical schools in Asia was then finding its way on to the world market. In the U.K. these doctors found many vacancies as 'trainees' in provincial hospitals and in certain specialties such as psychiatry and geriatrics. Before long, it was not uncommon to find every non-consultant post in a Northern or Midlands hospital occupied by an overseas graduate. However, a large proportion of these doctors were not really 'trainees' in the sense of being seriously committed to qualifying in a specialty and then practising

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it permanently, nor in the sense that they were receiving any systematic instruction.

The D.H.S.S. continued to maintain that there was such as excess of trainees in psychiatry that doctors should actually be discouraged from entering the specialty. A closer look at the actual S.H.Os and registrars, though, would have shown them to be little more than a stage army. In 1972, Professor Gerald Russell's analysis revealed how ominous the manpower situation really was (4). But well before that, anyone familiar with appointment committees for consultants in the non-Metropolitan regions would have been aware of an alarming fall in both numbers and quality of candidates. We were starting to reap the results of years of mismanagement, covered by the immigration of doctors who would mostly not qualify for eventual appointment as consultants. There are now almost 1,100 vacant consultant posts in the N.H.S., mainly outside the South East of England and mostly in the less popular specialties, which of course include psychiatry. As I pointed out recently in the *B.M.J.* (5), provincial appointment committees are constantly torn between the need to preserve reasonable standards and the urgent demands of the hospital concerned that someone must be found to keep the service going.

What is the present situation? In September 1973, the Metropolitan Regions, with a population of 14,237,000 had 2.82 consultants per 100,000 population (in whole-time equivalents), 0.82 senior registrars and 1.82 registrars; 46 consultant posts were vacant. The non-Metropolitan Regions of England and Wales, with a population of 32,188,000 had 2.12 consultants, 0.40 senior registrars and 0.86 registrars; 87 consultant posts were vacant. There are obviously major differences between these staffing levels, but a clear analysis of the averages shows even more striking discrepancies. The Manchester Region (1.51) had less than half the South-West Metropolitan's level of consultants (3.31). Sheffield's senior registrars (0.18) were little more than a tenth of the South West Metropolitan's (3.31). Registrars in Wessex (0.57) were less than a third of the North West Metropolitan's (1.65). Not only are the provincial regions enormously worse off in terms of their medical establishment, they have twice as many unfilled vacancies. Furthermore, an analysis of those doctors occupying training posts in the non-Metropolitan Regions would show an even gloomier picture, since a high proportion of them could not reasonably be expected to become consultants without a catastrophic fall in the general standard maintained up to now. The overall situation for academic and research posts is little better.

Though the front line of mental health services may be fairly well manned at present, there is an alarming lack of recruits behind it. Both the College and the D.H.S.S. must surely take some fundamental decisions very soon about distributing medical manpower (or personpower) more justly and about finding other ways of maintaining a reasonable quality of service. For a start, we should be offering proper inducements to every married woman doctor who could possibly be persuaded to resume part-time work.

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