The College

Report of The Manpower Working Party:

Medical Manpower in the Psychiatric Specialties
Report to Council by Manpower Committee, January 1981

In the last decade the policy of Government to allocate resources for the care of the elderly and the mentally ill and handicapped has been reflected in both consultant and non-consultant expansion in the psychiatric specialties. In 'Better Services for the Mentally Ill' (HMSO 1975) the Government set a target of one consultant per 40,000 population to treat adult mental illness in England and Wales. The Department of Health and Social Security's discussion paper 'Medical Manpower—the next 20 years' notes that over the past few years the actual growth in real resources available for the NHS in volume terms has been 3 per cent per year. The discussion paper concludes that 'on the more pessimistic view that long-term growth will only be 2.5 per cent per year the increase in doctors we could afford would be 1 per cent a year'. The latest information on Government intentions, as far as spending in the Health Service is concerned, is contained in a letter from the Secretary of State to the BMA in which he says that the Government intends to maintain the plans for NHS expenditure in gross terms implied in the last Government's Public Expenditure White Paper, Cmnd 7439 which provided for an increase in health authorities' revenue expenditure of a little less than ½ per cent in 1980–1 and of about 1.6 per cent a year thereafter up to 1982–3. (*British Medical Journal,* 16 February 1980, page 502). This may suggest a likely slowing in the number of new doctors to be employed at least during the period of recession unless resources are diverted from other areas. Continued expansion in psychiatry will thus require a clear statement of its priority in relation to other specialties. In the course of 1979 both the Royal Commission on the National Health Service (HMSO 1979) and a Working Party of the Council of the British Medical Association produced reports proposing changes in the career structure of doctors in the Health Service, and in 1980 the Joint Consultants Committee considered proposals prepared by its chairman. So far none of these proposals appears to have received sufficient support to become policy in the immediate future and the following discussion is in terms of the existing Health Service grades for doctors. While it will be seen later that the training grades in adult mental illness must take account of developments in other specialties, the latter are discussed separately.

Child and Adolescent Psychiatry

The number of consultants in Child and Adolescent Psychiatry has increased from 177 (143 whole-time equivalent) in 1970 to 296 (264.3 wte) in 1980, an increase of 67 per cent (85 per cent wte). The proportion of consultants born outside the British Isles has remained around 20 per cent. In the same period the number of SHMOs and associate specialists has decreased from 5 to 3. The number of senior registrars has increased from 37 (37 wte) to 76 (66.8 wte), an increase of 105 per cent (80.5 per cent wte) and the proportion born outside the British Isles from 16 per cent to 27 per cent. The number of registrars has increased from 15 to 25 or by 66 per cent and the proportion born overseas from 27 per cent to 60 per cent. The number of SHOs and HOs has risen from 3 to 16. The proportion of female consultants has risen from 29 per cent to 37 per cent. The proportion of female senior registrars has remained fairly constant at 41-44 per cent but all except one of the part-time senior registrars are female. In 1970, 50 per cent of male and 63 per cent of female consultants were part-time. In 1980, 30 per cent of male and 44 per cent of female consultants were part-time. Between 1974 and 1979–80 senior registrar posts advertised attracted between 3 and 4 applicants per post, 26 per cent of advertised posts were unfilled and the average age of those appointed was 30. Candidates have spent on average 8 years since qualification and 3.2 years as a registrar. Consultant posts within the same period attracted between 2 and 3 applicants per post; 23 per cent of posts advertised were unfilled. Applicants had spent on average just under 3.1 years as a senior registrar and were aged 35 on appointment.

The Department of Health's target for Child and Adolescent Psychiatry is one consultant per 200,000 population while the College (*News and Notes,* December 1973), recommended 1½ consultants as a realistic minimum for this population, together with junior staff in training. While it might appear that the DHSS target has been achieved nationally, about 30 extra consultant posts would be required to correct regional differences and bring understaffed regions up to target. A further 70 posts would be required to achieve the College's target and 140 posts to meet the longer term aim agreed in 1980. Some new posts will be obtained because of the regrading of local authority child psychiatrists in Health Service grades in the past year, but at the same time there has been a decline in applications for new consultant posts in the specialty.

Child and Adolescent Psychiatry is an interesting specialty from the manpower point of view as three quarters

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of the doctors involved are consultants and consultants clearly carry the largest part of the service commitment. The specialty entails little emergency work and the average contracted hours of duty of the junior staff rank 41st of 50 listed specialties. Because of this pattern of work it is unlikely that the specialty will serve as a model for other areas, and the very existence of the pattern may create problems for in-patient units where cover may be necessary. At the senior registrar level 10 further posts over the next 5 years (perhaps on a one-holder basis) would be needed to correct regional maldistribution, which roughly coincides geographically with consultant maldistribution. Compared with all medical specialties there are fewer consultants over the age of 60 and rather more between the ages of 50 and 60. This may imply a potential bulge of retirements in 5 to 10 years, and the proposed senior registrar expansion would be useful to meet this.

While training in child psychiatry is normally commenced at the senior registrar level, as long ago as 1973 the College recommended an expanded registrar grade to allow registrar rotational training programmes, not only by those 'who have decided to commit themselves to the specialty, but to those who wish to have a preview of the specialty before committing themselves'. These posts were required not only for psychiatrists but 'for doctors in the field of paediatrics, general practice and community child health'. Such posts would have an important role in the core training recommended in the Court report ('Fit for the Future', Cmnd 6684, 1978). Again, a few one-holder posts would be helpful.

Psychotherapy

Recording of psychotherapists from the manpower point of view was introduced only a few years ago, and it is unlikely that Departmental statistics reflect the true position at the consultant level. The College Specialty Committee in Psychotherapy is at present collecting accurate data. At any rate the College's immediate aim is to provide five sessions for an average district of 200,000 people and this would imply an immediate need for 114 whole-time equivalent consultants in England and Wales.* Because of the work pattern of psychotherapists, most of whom are part-time, this implies a very much larger number of persons. An analysis of posts advertised between 1979 and 1980 showed only 9.5 per cent of posts unfilled after interview, and just over 6 applicants per post. The average age on appointment was about 34, after just over 3.7 years in the senior registrar grade. An analysis of senior registrar posts showed an average of 2–8 applicants per post, a proportion of whom were already senior registrars, probably in mental illness or child and adolescent psychiatry. Of 7 senior registrars in post in 1977, none had been in the grade less than two years and three had been in post over four years. Of ten senior registrars in post in 1978, four were in post over four years, and of these three, over five years. By 1980, of 17 senior registrars only one was in post over four years and none in 5 years. In 1980, eleven out of fifteen regions in England and Wales had no senior registrar in psychotherapy, while six regions had no consultant psychotherapist. While it remains important to obtain more accurate information, there is clearly room for expansion at both senior registrar and consultant grades, but it will be difficult to make the case for the former until application for the latter exceed the number of senior registrars who have completed training.

*See: '"Norms" for Medical Staffing of a Psychotherapy Service . . .' (See References.)

Forensic Psychiatry

Forensic psychiatry established a separate training programme in 1972. In 1980, eighteen consultants were in post. With the accelerated development of the secure unit programme which is anticipated in the 80's, the College estimates that another 30 consultants may be required. There are only ten senior registrar posts in the specialty, and of those two were unoccupied in 1980, suggesting that there is some difficulty in attracting suitable candidates. Expansion is clearly indicated at both levels, and there is also room for registrar posts which may give a preview of the specialty in rotational training schemes and attract entrants. There is no manpower objection to these developments at centres likely to attract applicants. It is noted that the average contracted hours for junior medical staff in the specialty are even lower than those in child and adolescent psychiatry and considerably lower than those for mental illness, although the specialty, despite its limited existence, has in general a hospital base. It is expected that the above expansion will be complemented by a number of psychiatrists with a special interest, derived from senior registrars who have participated in rotational training schemes.

Mental Handicap

The number of consultants in mental handicap rose from 117 (113.7 wte) in 1970 to 152 (147.9 wte) in 1980, an increase of 30 per cent (30 per cent wte). The number of female consultants innreased from 15 to 37, while males increased from 102 to 115. The number of consultants born outside the British Isles rose from 18 per cent in 1970 to 37.5 per cent in 1980. The number of SHMOs and associate specialists fell from 51 in 1970 to 38 in 1980, while the number of senior registrars increased from 10 to 21 in that time. In 1970, eight of the senior registrars were born within the British Isles—in 1980, four. There is an excess of consultants aged between 50 and 60 in relation to all medical specialties. The number of registrars has increased from 26 in 1970 to 48 in 1980 and the number born in the British Isles likewise rose from 7 to 8 in the same period. The number of SHOs has risen from 7 to 16, the number born in the British Isles falling from 3 to 1. The number of contracted hours for junior staff is higher than for mental illness and ranks 25th of 50 specialties listed. Between 1972 and

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1980, there were on average 2.7 applicants for each senior registrar post and 25 per cent of posts remain unfilled. Sixty-seven per cent were filled by overseas graduates, the average age of appointment was 39 and between two and three years had been spent as a registrar. The age at which consultants were appointed appears to be falling from around 46 in 1972 to 38 in 1977. The average period as a senior registrar rose from 2.8 years in 1972 to 3.2 years in 1980. The number of unfilled posts rose progressively from 3 in 1972 to 14.8 in 1980. In 1980, 208 (68.7 wte) clinical assistants provided on average less than four sessions.

To provide one consultant in mental handicap for 200,000 population would require 250 whole-time-equivalents in England and Wales. There is clearly scope for developing the infrastructure in mental handicap in order to provide consultant expansion. There is no manpower objection to development in both the senior registrar and registrar grades, but because of the large number of vacant posts this can only usefully take place at centres which can attract candidates or, at the registrar level, in rotational training schemes which expose other psychiatrists to the specialty. In 1980, 23 of 48 registrars had been in the grade for more than two years, while 8 of 16 SHOs had been in that grade for more than a year. Twelve registrars had been in the grade for more than four years. These figures suggest that the occupants were unlikely to be in training and might be more suitably employed in a non-consultant career grade. The figures also suggest that the true position of the training grades is even more serious than appears at first sight.

Psychiatry of Old Age

With about half the resident patients in psychiatric hospitals and 22 per cent of new admissions over the age of 65 years, a substantial proportion of all psychiatric time must already be concerned with the elderly. The anticipated increase to the end of the century in the elderly population in the community, particularly those aged 75 and over will require further expansion of psychiatric manpower directed to the treatment of the elderly. In almost half the Health Districts in this country, consultants have been appointed with, or have undertaken, a special interest in the Psychiatry of Old Age, although at present many have only a few sessions formally allotted to the task. The College envisages that in time each District will have at least one and possibly two or more consultants with this interest.

The College's immediate aim is to provide one whole-time equivalent consultant in an average District with a population of 200,000. (This would mean 250 wte out of the present 950 wte in general psychiatry or 350-400 individuals if many were part-time.) Such a District would contain 30,000 over the age of 65. The Section for the Psychiatry of Old Age considers that an effective psychiatric service for the elderly requires rather more—a minimum of one wte consultant for 25,000 elderly people. These consultants will be provided from the general psychiatry manpower pool. There should be opportunity for trainees undertaking general professional training at registrar level to rotate through a psychogeriatric unit and at senior registrar level it is essential that trainees should have the opportunity to obtain psychogeriatric experience. At present (Dr Wattis—University of Nottingham, 1980) there are only six NHS senior registrar posts in the Psychiatry of Old Age occupied more than half-time in England, Scotland and Wales, most of them rotating with other general psychiatry senior registrar posts. It has been recognized that opportunities at senior registrar level require expansion, and seven one-holder senior registrar posts have been allocated to be placed in psychogeriatric centres which are linked with rotational training schemes. The College proposes that in the immediate and long-term future the ratio of consultants in psychogeriatrics to those in general psychiatry will be 1:3 whole-time equivalents. Assuming psychogeriatricians spend on average 6-7 sessions in the specialty, the ratio in numbers would be 1 : 1.5-2 and for the necessary senior registrars to spend a minimum of one year in psychogeriatric training would require about 40-48 posts if senior registrars spend an average of two years in the grade before a consultant appointment or 27-32 posts if they spent three years in the grade. This would imply 2-3 posts in each region.

Dependencies, Drugs and Alcohol

The majority of the suggested 90 whole-time-equivalent consultants working in the dependencies will be general consultants with a special interest. Training and experience will have been gained in registrar and senior registrar rotations or by secondment of consultants to special units. The average District will be expected to provide about four sessions for the dependencies, and, where special units exist a consultant may spend the whole or the majority of his time in the field. Manpower provision is from the general psychiatric pool, and the problems are educational rather than related to manpower.

Special Interest Posts

While the exact allocation of specific sessions would be a matter for local arrangement, consultants 'with a special interest' would be expected to give a substantial part of their time to the special interest which would generally mean about five sessions. The creation of special interest posts will be also a matter for local arrangement. It would be desirable that such posts should be considered when retirement vacancies in general psychiatry occur in those Districts where there are insufficient sessions for the special interest (Psychiatry of Old Age, Alcoholism, or other).

General Psychiatry

Manpower statistics published by the Department of Health and Social Security in 1970 included forensic psychiatrists and psychotherapists with general psychiatrists and the comparisons which are presented below include

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Table 1. All staff—comparison of 1970 and 1980—adult mental illness (including psychotherapy, forensic psychiatry)

Associate Specialist	Consultant/ SHMO with award (wte)	SHMO+ AS (wte)	Senior Registrar (wte)	Registrar (wte)	SHO (wte)
1970	822 (712)	298 (280)	176 (156)	468 (464)	200 (198)
1980	1165 (1055)	213 (192)	304 (255)	698 (674)	756 (745.8)
	+41% (48%)	−29% (−31%)	78% (63%)	+49% (45%)	+278% (276%)
All specialties	+37%	−9%	+75%	+28%	+93%

Table 2. All staff born in the British Isles—comparison of 1970 and 1980—adult mental illness (including psychotherapy, forensic psychiatry)

	C+SHMO with award (wte)	SHMO+AS (wte)	SR (wte)	R	SHO
1970	694 (605)	203 (187)	130 (133)	165	80
1980	820 (736)	110 (91.1)	186 (153)	244	361
	+18% (22%)	−46% (−51%)	43% (35%)	+48%	+451%
All specialties	+25%	−11%	+68%	+40%	+166%

similar groups for the year 1980. It will be appreciated from the sections above that the numbers involved in these specialties are very small and provide little infiuence on the overall figures (84 psychiatrists of all grades in forensic psychiatry and psychotherapy in 1978).

It will be seen (Table 1) that the increase in the number of consultants in adult mental illness (41 per cent) exceeded that for consultants in all specialties (37 per cent). On the other hand, the fall in the number of associate specialists and SHMOs also exceeded that for all specialties suggesting a higher rate of promotion from these grades to the consultant grade in psychiatry. Increase in senior registrars (78 per cent) was more than that for all specialties (75 per cent) while those for registrars and SHOs were double and treble the increase noted for all specialties. When the situation is examined for all doctors born in the British Isles (doctors who roughly equate with those who qualified in the British Isles), a rather different picture emerges (Table 2).

The increase in consultants between 1970 and 1980 is 18 per cent as against 25 per cent for all medical specialties. The increase in senior registrars is 43 per cent as against 68 per cent in all specialties. On the other hand, the increase in registrars and SHOs from the British Isles is higher in general psychiatry than for all specialties but these improvements in recruiting are not working their way through to the senior registrar grade. This suggests that both SHO and registrar grades in mental illness may be used by British graduates as training for other specialties or general practice.

The pattern for males and females in psychiatry is also somewhat different from that seen in all specialties. The increase in male consultants (from all places of birth) is a little higher than the increase for male consultants in all specialties. The percentage increase for female consultants is, however, nearly three times higher in psychiatry compared with all specialties. The fall in male SHMOs and associate specialists is greater in psychiatry than for all specialties and there is a fall in the number of females in these grades in psychiatry, as against an increase in the number of females in all specialties. The increase in male senior registrars in psychiatry is less than that for all specialties, but the increase in female senior registrars is greater than that for all specialties. The increase in registrars and SHOs born in the British Isles exceeds that for all specialties, and this increase is proportionally greater for men.

In summary then, while there has been considerable expansion in the consultant and training grades in psychiatry and that in the consultant grade has exceeded the percentage expansion in all specialties, it has not been entirely the result of British graduates turning to psychiatry—on the contrary the percentage increase is about the same as that for all specialties, and 190 new consultant posts have been filled by overseas graduates. The increase in British graduates interested in general psychiatry at the registrar and SHO levels is not matched by a comparable increase in senior registrars (Table 2). Psychiatry is running down the SHMO and associate specialist grades, more rapidly than all specialties and particularly as far as women are concerned. While other medical specialties are running these grades down more slowly for men, they are actually increasing the use of the grades for women. The percentage increase in women working in mental illness in the training and consultant grades exceeds that seen for women in all specialties, and is particularly important as far as the consultant grade is concerned (Table 3).

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The College's Policy for Adult Psychiatry

The College's policy for consultant staffing in adult psychiatry is set out in 'Providing a District Service for General Psychiatry' (*Bulletin*, December 1977) and 'Medical Manpower Requirements at Teaching Hospitals in Adult Psychiatry' (*Bulletin*, December 1978). These statements imply a need for a further 330 consultants. The number of consultant posts not occupied has, however, risen from 15 in 1970 to 58 in 1979, but the number of senior registrar posts not occupied only from 9 to 11 in the same period of time. There is nevertheless a higher than average proportion of vacancies at the consultant and senior registrar level. Implementation of College policy as far as consultants are concerned would appear to rest on the continued recruitment of doctors from overseas and on maintaining the current trend which shows increased interest by women in psychiatry. College policy is to seek to maintain about 33 sessions for general psychiatry in an average district with a population of 200,000 and to develop the special interests and specialties, giving priority to those areas where practical needs must be met, for example, the psychiatry of old age and alcohol dependence. At the same time, there is known to be a very uneven distribution of consultant manpower and workload in the different regions of the country (Table 4).

This will be resolved by encouraging relatively greater expansion in undermanned regions in relation to that permitted in the best staffed regions of the country. To produce selective expansion there should be room for an increase in the number of senior registrar posts available to doctors with and without domestic commitments in undermanned regions, perhaps on a temporary basis.

Non-consultant Grades

The College's policy on non-consultant medical staffing for adult mental illness has been set out for consideration by a recent Working Party in its report dealing with teaching hospitals and psychiatric hospitals and units (*Bulletin*, December 1978). Broadly speaking, the 1,000 consultants in post are thought to require 2,000 non-consultants to provide support in service areas and because of the special commitments of trainees it is suggested that five trainees would be required to provide the service commitment of four non-consultant career grade doctors. In 1979 about 450 wte were provided by the latter and 1,350 by trainees, who may therefore be seen as supplying approximately 1,100 whole-time service equivalents. The residual service need of 450 non-consultant doctors is not likely to be met by expansion in the registrar grade although bearing in mind the expansion planned outside mainstream psychiatry there will still be room for some appointments in those regions below the national average able to provide satisfactory training. National tables indicate that the proportion of registrars in post for more than two years is 55 per cent in mental illness as against 36 per cent in all specialties. A recent survey organized by the Regional Adviser and Dean in the South West Thames Region has shown that 33 (out of a total of 77) registrars had been in the grade for more than five years, and one doctor had been in the grade for 19 years. Applications for personal grading as associate specialist confirm the existence of a number of doctors in the registrar grade who do not wish to compete for consultant appointments. The College Working Party on the Non-Consultant Non-Training Grades in Psychiatry supports the proposal that

Table 3

All places of birth *Males*				GB and Eire born	
Mental illness	C/SHMO with award (wte)	SHMO/AS (wte)	SR (wte)	R	SHO
1970	761 (678)	190 (184)	148 (131)	113	51
1980	1006 (917)	113 (109)	225 (187)	133	211
% change	+32% (+35%)	−41% (−41%)	+48% (+43%)	+18%	+333%
All specialties	+25%	−27%	+65%	+26%	+127%
All places of birth *Females*					
Mental illness	C/SHMO award (wte)	SHMO/MA (wte)	SR (wte)	R	SHO
1970	41 (23.8)	108 (97)	28 (25)	52	29
1980	153 (138)	100 (83)	89 (68)	111	157
% change	+273% (480.1%)	−7% (−14%)	+318% (+27%)	+113%	+441%
All specialties	+100%	+38%	+154%	+102%	+308%

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Table 4. Consultant workload by Regions: 1978[1]

	WTE Consultant/ 100,000 Population tion (Rank)	Admissions/ Consultant (Rank)	Residents/ Consultant (Rank)	OP Attendances/ Consultant (Rank)	DP Attendances Consultant (Rank)	Total Rank
Yorkshire	1.69 (2)	243 (1)	113 (2)	1755 (7)	4298 (2)	14
Trent	1.57 (1)	210 (3.5)	93 (4)	1857 (4)	3606 (5)	17.5
North Western	1.83 (5)	210 (3.5)	80 (10)	2175 (1)	4362 (1)	20.5
Mersey	1.73 (3.5)	241 (2)	135 (1)	1740 (9)	2709 (10)	25.5
East Anglia	1.73 (3.5)	193 (5)	85 (7)	1746 (8)	2873 (8)	31.5
Northern	2.00 (9)	188 (7)	88 (5)	1756 (6)	2830 (9)	36
South-East Thames[2]	2.01 (10)	187 (8)	86 (6)	2077 (2)	2430 (13)	39
West Midlands	1.86 (6)	177 (9)	76 (11)	1614 (11)	4272 (3)	40
South Western	1.89 (7)	189 (6)	83 (9)	1204 (14)	3291 (6)	42
South-West Thames	2.54 (14)	164 (11)	95 (3)	1993 (3)	2590 (12)	43
Oxford	1.94 (8)	140 (14)	49 (14)	1517 (12)	3950 (4)	52
North-East Thames	2.40 (12)	157 (12.5)	70 (12)	1822 (5)	2616 (11)	52.5
Wessex	2.25 (11)	175 (10)	65 (13)	1245 (13)	3285 (7)	54
North-West Thames	2.48 (13)	157 (12.5)	84 (8)	1644 (10)	2174 (14)	57.5

[1] Activity figures are provisional.
[2] Excluding postgraduate teaching hospitals.
Source: DHSS Manpower Return, September 1978.
Mental Health Enquiry, 1978.
Facilities return, 1978.

candidates who have reached a specified basic level of postgraduate training and do not wish to progress towards a consultant appointment might be appointed to a new grade of 'Hospital Practitioner Non-GP'. Failing the extension of the hospital practitioner grade, the Working Party recommended the wider use of the associate specialist grade for the special needs of psychiatry and the continued use of the clinical assistant grade to meet service needs, particularly where the work involved did not require specialist skills. There has subsequently also been some expansion in the hospital practitioner grade—occupied by general practitioners with two years past service in the specialty, and this expansion should be encouraged.

The BMA Council Working Party Report 'Medical Manpower Staffing and Training Requirements' (*BMJ*, 19 May 1979) recommended that the role and terms of conditions of service of doctors appointed under Para. 94 of the 'Terms and Conditions of Service of Hospital Staff (Clinical Assistants)' should be the subject of comprehensive review while existing policy should be maintained as far as the associate specialist grade is concerned. This grade is a permanent career grade of limited responsibility established for doctors who, on a personal basis, apply for employment as associate specialists. The applicants might normally have had three years post-registration hospital experience, including two years at registrar level or equivalent.

With vocational training now compulsory for general practice and having regard to the importance of psychiatric experience for general practitioners, the expansion of SHO posts which has already been undertaken for this purpose may continue within the above framework, but to a more limited extent. To correct regional maldistribution in the support and training grades, the College would again wish to encourage more rapid development in those regions under the national average. The support staffing of the district general hospital units which have often been opened in periods of financial restriction must, however, also enjoy some degree of priority within all regions.

Pre-registration posts may encourage entrance to psychiatry, and such posts may now be created in suitable hospitals. It is anticipated that they will supplement the existing training grades and not replace them.

Secretarial Support

The estimates for consultants in all branches of psychiatry are based on the assumption that the consultant has proper secretarial and administrative support. The secretarial and administrative tasks are diverse and include all the duties listed in Paras 3.1-3.5 in the Report on Secretarial Services for Hospital Medical and Dental Staff (Joint Consultants Committee, 1978). The College supports the view that this complex range of tasks requires not only resource, initiative and maturity but training and experience as well as the personality characteristics implied in Paras 4.3a-d of the above Report. The College believes that the work of psychiatrists differs from that of other consultants and that this demands that the consultant's personal secretary should always exercise initiative and resource to a significantly greater

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degree than that appropriate to those in the clerical grade and recommends that this support should be supplied by personal secretaries in the Higher Clerical Officer grade.

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College Recognition of Psychiatric Tutors

A scheme for granting Psychiatric Tutors, Specialty Tutors and Course Organizers formal recognition was introduced in 1977 for a trial period to allow the criteria for recognition and the application form to be tested. Both the criteria and the application form have been modified as a result of the trial period and have now been approved by Council. The criteria are printed below.

A list of College Recognized tutors and course organizers is held at the College and copies may be obtained on request to Jane Boyce, Education Department. It is appreciated that members of the College may not wish to have a complete list, and separate lists of recognized tutors in the College's various Divisions can be supplied.

Some tutors may not have applied for College Recognition so far, and they are now invited to do so. Application forms will be sent on request to Jane Boyce. Tutors who have already been recognized by the College do not need to re-apply.

THOMAS BEWLEY
Dean

Council has approved a scheme for granting formal recognition to individuals appointed as Psychiatric Tutors, Specialty Tutors and Organizers in the field of postgraduate education. The College is not concerned with the creation of such posts or the appointment of individuals to them, but wishes to make their position more formal by providing criteria for their recognition and establishing standards by which they are chosen, and doing this in a way which it is hoped will be acceptable to and welcomed by Universities, Postgraduate Councils and other bodies.

Principles

1. The following definitions will apply for the purposes of Recognition:

   (a) *Psychiatric Tutor:*
   An individual identified in his hospital or group of hospitals as the person responsible for postgraduate psychiatric training and education and who is in regular weekly contact with his trainees.

   (b) *Psychiatric Tutor (Specialty):*
   A psychiatrist practising in the fields of child and adolescent psychiatry, psychotherapy, forensic psychiatry, mental handicap, psychogeriatrics or the dependencies (drugs/alcohol) who is regarded in a region as a tutor in that specialty.

   (c) *Psychiatric Tutor (Course Organizer):*
   A psychiatrist usually (but not necessarily) holding an appointment as senior lecturer in a University department who has the task of organizing day release courses and similar teaching activities.

2. Care will be taken to ensure that the process of College Recognition does not damage existing arrangements where these are satisfactory. The criteria will be applied flexibly to allow for variations between regions in the organization of postgraduate education.

3. College Recognition is intended to strengthen the tutor's position and thereby benefit the trainees whom he serves.

Criteria for Recognition

(a) *Qualifications:* Tutors must be medically qualified and

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