# Too many patients; too few psychiatrists

*David Storer*

The above was, approximately, the title of a session at the 1998 College Annual Meeting in Belfast. Some in the audience expected the speakers to stand up, agree with the propositions in the title, and resume their seats.

However, a more complicated, and more positive, picture emerged during the presentations. In both parts of Ireland recruitment to the current number of posts is satisfactory. In Scotland the picture is improving. In England and Wales severe shortages, particularly at consultant level, remain but even here there are signs of improvement. As we obtain more reliable information and gain experience in the relatively new medical workforce planning arrangements, particularly Specialty Workforce Advisory Group (SWAG) in England and Wales, we see a picture presenting different problems in different localities and in the six specialities within psychiatry.

Table 1 is prepared from data collected by the College Annual Census (Royal College of Psychiatrists, 1997). It shows consultant expansion in each of the specialities (the apparent nil expansion in psychotherapy is likely to be an artefact – the 1996 Census reported 125 consultant psychotherapists in post). The number of consultants in old age psychiatry has increased by almost a quarter during the three-year period; in contrast the increase in learning disabilities has been marginal.

Table 2 demonstrates an increase in consultant vacancies in most specialities despite the increase in numbers in post. This indicates that trusts are trying to expand the consultant grade more rapidly than the supply of Certificate of Completion of Specialist Training holders allows.

Table 1. Consultants in post (England and Wales)

| | 1994 | 1997 | Percentage increase |
|---|---|---|---|
| General psychiatry | 1232 | 1321 | 7.2 |
| Old age psychiatry | 304 | 377 | 24.0 |
| Child and adolescent psychiatry | 401 | 446 | 11.2 |
| Learning disability | 196 | 201 | 2.6 |
| Forensic psychiatry | 102 | 126 | 23.5 |
| Psychotherapy | 119 | 119 | 0 |
| Total | 2354 | 2590 | 10.0 |

Table 2. Consultant vacancies (England and Wales)

| | 1994 | 1997 | Percentage of total number of posts | Change |
|---|---|---|---|---|
| General psychiatry | 140 | 222 | 14.4 | +82 |
| Old age psychiatry | 56 | 71 | 15.8 | +15 |
| Child and adolescent psychiatry | 45 | 42 | 8.6 | −3 |
| Learning disability | 15 | 31 | 13.4 | +16 |
| Forensic psychiatry | 16 | 25 | 16.5 | +9 |
| Psychotherapy | 10 | 11 | 8.5 | +1 |
| Total | 282 | 402 | 13.5 | +120 |

While the seriousness of these vacancy rates should not be understated, and certainly the pressures on psychiatrists working in circumstances where they are having to cover for long-term vacancies are even greater than those in fully staffed areas, there is some ground for optimism as the number of consultant vacancies in England in 1997 is slightly less than in 1996.

Although our College Census obviously only collects data for the psychiatric specialities, we can make comparison with other specialities by looking at the NHS Census (Department of Health, 1998). It shows that consultant expansion in psychiatry has been falling behind the overall rate in all specialities. Over the period 1987–97 consultant expansion in psychiatry was 2.9% per year, compared with 3.6% in all specialities. For the five-year period 1992–97 the rates were 3.7 and 4.3% respectively. However, for the year 1996–97, the picture for psychiatry is encouraging, 5.9% compared with 4.2% average for all specialities.

The reasons why consultant expansion in psychiatry has lagged behind that in other specialities are connected with supply rather than demand. This is indicated partly by the fact that vacancies have increased as have consultants in post, and also because we know that trusts (providers) and health authorities (commissioners) would create more consultant posts if they believed that they could recruit to them (National Health Service Executive, Royal College of Psychiatrists & NAHAT, 1996; Medical Staffing in Mental Health. The Report of a Working Group



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to the Medical Director of the NHS Executive: further details available from the author upon request). This is known in the jargon of workforce planning as 'suppressed demand'.

For some years the supply of trained applications for consultant posts was restrained by insufficient senior registrar posts in psychiatry leading to a 'bottleneck' between the registrar and senior registrar grades. However, we now have around the number of specialist registrar posts which we can fill from those passing the membership examination each year. SWAG have continued to recognise the shortage of consultants by recommending a modest increase in specialist registrar numbers each year across the psychiatric specialities. In 1998 there has, for the first time for some years, been an increase in the numbers entering and passing the MRCPsych examination.

In order to provide enough applicants for the MRCPsych we require sufficient senior house officers (SHO) posts. Neither the College Census nor the NHS equivalent are particularly accurate with regard to this grade. This is, at least partly, because of the 'merging' of the registrar and SHO grades post-Calman and partly because some SHO posts in psychiatry are clearly intended for trainee psychiatrists, some for trainees in general practice and others available for either purpose. However, it would appear that there are insufficient posts to meet the training needs of both specialities. It has been almost impossible to create new SHO posts in recent years but the 'freeze' has now been slightly relaxed to allow some new SHO posts, provided that they are dedicated to setting up posts for training in learning disability; this is a recognition of the recruitment problems in that speciality.

The supply of recruits to the SHO grade does, of course, depend on persuading enough pre-registration house officers and, therefore, medical students, that they would like to do psychiatry. The Parkhouse data (Lambert *et al*, 1996) indicates that the number of medical students saying that they wish to take up our speciality has been fairly steady at 3.5–4.0% of the total for some years. However, given the recent drop in popularity of general practice among undergraduates we may have expected to see evidence that we were recruiting some of those disaffected by primary care.

Information collected by the Parkhouse surveys on what governs choice of career would indicate that there is potential for us to make our speciality more attractive. The 'top five' factors influencing career choice given by doctors one year after qualification are:

(a) Hours or working conditions.
(b) Domestic circumstances.
(c) Particular teacher or department.
(d) Experience of jobs so far.
(e) Experience of speciality as a student.

All are open to influence in that we should be able to offer more flexible hours and working conditions than most specialities and we can make undergraduate attachments and first SHO placements interesting and enjoyable.

The relative unpopularity of psychiatry to medical students is not exclusive to the United Kingdom. Sierles & Taylor (1995) report that in 1994, 3.2% of US medical school graduates chose psychiatry, the lowest proportion since 1929. Interestingly they suggest that recruitment to psychiatry has declined as American psychiatry has become more 'medical'. In Britain, Thompson & Sims (1998; further details available from the author upon request) have postulated that psychiatry's popularity has waned partly due to the shift of psychiatry away from general hospitals and the mainstream of medicine. It would be useful to know more about the 'push' and 'pull' factor leading to recruitment and retention in our speciality.

What about the second part of my title? Are there too many patients? Numbers of referrals are certainly increasing. Those of us who deal with referrals from general hospital accident and emergency departments are uncomfortably aware of that and all areas of psychiatry report the same trend. Arguments for an expansion in the number of psychiatrists are usually met with a request to consider 'skill mix'. This is shorthand for a suggestion that many of those seen by psychiatrists could be adequately dealt with by others, particularly psychiatric nurses. Apart from the argument that this leads to an increase in secondary referrals to psychiatrists it begs the fact that there are also shortages of psychiatrically trained nurses.

At the Annual Meeting the speakers were left in no doubt by the audience that the increasing pressure that psychiatrists feel can only be reduced by an increase in the number of psychiatrists.

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David Storer, *Consultant Psychiatrist, General Infirmary at Leeds, Great George Street, Leeds LS1 3EX*