Malaise in psychiatric recruitment and its remedy

D. J. Thompson and A. C. P. Sims

Aims and method Surveys of career intention among medical students, Membership Examination results and manpower figures are used to examine trends in recruitment to psychiatry over the last 10 years.

Results Problems of recruitment to psychiatry have increased. Consultant expansion contrasts with a fall in the number of medical students. The increase in the number of career senior house officers and specialist registrars is insufficient to fill existing consultant vacancies notwithstanding new and replacement posts. The popularity of general psychiatry and psychotherapy have declined.

Clinical implications Proposals include an increase in the number of medical students, the introduction of psychiatry in the pre-registration year, increased specialisation and closer integration of general adult psychiatry with general medicine.

There are currently problems in recruitment to all grades of medical staff in psychiatry. Recently, vacancies for specialist registrars in general psychiatry have remained despite repeated advertising; it is not clear how widespread are these trends and whether all specialities of psychiatry are similarly affected.

Two issues require consideration, first, whether there are sufficient recruits to psychiatry to fill present and projected consultant vacancies and ensure good quality patient care, and second what variation exists between individual psychiatric specialities. Trends over the last decade will be used to explore this problem and offer some solutions.

Medical students

The proportion of medical students choosing psychiatry increased over the last decade (Parkhouse & McLaughlin, 1976; Lambert *et al*, 1997). Between 1974 and 1983 3.7% made psychiatry their first choice compared with 4.2% in 1993. Whereas 4693 medical students qualified in 1984 (University Statistics, 1984), only 4356 qualified in 1994 (Students in Higher Education Institutions, 1994/95). Thus, although 174 students placed psychiatry as their first choice in 1984 (3.7% of 4693), only 183 did so in 1994 (4.2% of 4356), an increase of only nine medical students.

Senior house officers

Of the 1217 senior house officers holding posts in 1995, some were pursuing a future career in psychiatry with the majority of the rest training for general practice. The number of trainees passing the Part 1 Examination for Membership indicates serious interest in psychiatry as a career choice; 317 passed the Part I Examination in 1985 compared with 355 in 1995, an increase of 10.7%. However, the number of trainees passing the Part II Examination and hence becoming Members of the College showed only a 3.6% increase, from 318 in 1985 to 330 in 1995.

Psychiatry also recruits from doctors in placements as part of other rotations, particularly Vocational Training Schemes for General Practice. However, medical students placing general practice as their first choice fell from 37.6% of those surveyed in 1983 to 25.8% in 1994 (Lambert *et al*, 1997). This decline in the popularity of general practice will decrease consequent entrants to psychiatry.

Specialist registrars

The number of specialist registrars and senior registrars in psychiatry has increased over the period, from 435 in 1981 to 866 in 1994 and 962 in 1996 (Hospital Medical Staff, 1981; Annual Census of Psychiatric Staffing, 1994, 1996). The popularity of different specialities within psychiatry can be quantified by calculating the number of vacancies as a percentage of the available posts in that speciality. We call this the 'vacancy factor', the higher the vacancy factor the less popular that speciality, assuming an equal rate of expansion in each speciality. The introduction of *Hospital Doctors: Training for the Future* (Department of Health, 1993), has seen overall vacancies for specialist registrars in psychiatry increasing from 1.7% in 1993 to 7.5% in 1995. The preferences for different specialities are presented in Table 1.

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Table 1. 'Vacancy Factor': the number of specialist registrar vacancies as a percentage of available posts and expansion of posts 1994–1996

Year	All specialist registrars in psychiatry	General adult psychiatry	Old age psychiatry	Child and adolescent psychiatry	Learning disability	Forensic psychiatry	Psychotherapy
1994	6.6	*	*	*	*	*	*
1995	7.5	8.8	7.2	3.6	23.9	7.1	21.2
1996	7.4	7.4	6.0	4.7	21.4	5.9	17.5
Expansion in 1994–96	+15.8%	+16.2%	+19.4%	+6.7%	+5.9%	+52.3%	+5.4%
Total specialist registrar posts in 1996	962	473	101	149	56	68	40

*, data unavailable.

Learning disability and psychotherapy have the highest vacancy factors, child and adolescent psychiatry the lowest. General psychiatry is now less popular than old age or forensic psychiatry despite higher rates of expansion in these latter specialities. This is particularly serious as general adult psychiatry represents approximately 50% of all specialist registrars and consultants in psychiatry. The figures for the number of specialist registrars suggest a maximum of 274 specialist registrars eligible for consultant appointments each year if the minimum time required by each speciality, is spent in higher training.

Consultants

The number of posts for consultant psychiatrists in England and Wales has increased by 58.4% over the last 13 years, from 1672 in 1981 to 2650 in 1994, and 2941 in 1996 (Hospital Medical Staff, 1981; Annual Census of Psychiatric Staffing, 1994, 1996). This represents an annual rate of expansion which varies from 4.5% per year representing 132 posts, to the current 7.2% equivalent to 200 posts each year. Assuming an average career of 30 years as a consultant psychiatrist, approximately 100 appointments need to be made each year simply to replace retirements. In addition it is predicted that approximately 50 early retirements occur each year (Kendall & Pearce, 1997). This suggests that consultant vacancies will increase by 350 posts each year at the present rate of expansion, in addition to the existing 394 consultants vacancies currently identified in England and Wales.

Recommendations

Recruitment must be improved at all levels. The fall in the number of medical students who qualified over the period provides powerful evidence to support the recommendations of the Campbell Report (1997) that the annual intake of medical students nationally should be increased by 1000 as soon as possible (Department of Health, 1997).

A properly constructed pre-registration house officer year which should include four months spent in psychiatry as part of a planned rotation could provide much needed improvement in communication skills for medical staff, and coincidentally positively assist recruitment into psychiatry.

There should be closer integration of general psychiatry with the rest of hospital medicine. The relatively low popularity for general psychiatry at specialist registrar level is a new phenomenon. It is the largest speciality and normally provides the first clinical experience for medical students. Its problems have been discussed in detail elsewhere (Deahl & Turner, 1997). Consultants describe being exposed to increasing responsibilities combined with limited resources over which they have little control. The 'inquiry culture' demands a scapegoat and effectively expects the responsible medical officer to accept unlimited responsibility for everything that goes wrong with the management of patients in the community. Sectorisation compounds the problem; it often leaves the consultant in general psychiatry in the position of underwriting other specialities and sub-specialities. It discourages specialisation in important areas of psychiatric activity.

Current proposals are displacing general psychiatry from district general hospitals to stand-alone community psychiatric units. This ignores both the likely adverse effect on recruitment at medical student and pre-registration level, and that liaison psychiatry is the most popular sub-speciality within general psychiatry.

There should be further development of specialist knowledge within general psychiatry. Specialist services exist, but are confined to certain conditions such as eating disorders or types of service – such as rehabilitation or

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liaison. Despite compelling research evidence, few psychiatrists implement the recommendations for reducing expressed emotion with the families of patients with schizophrenia (Leff & Vaughan, 1981) or use computerised tomography scans to inform treatment and likely prognosis (Lieberman *et al*, 1993). Equally, few psychiatrists treating patients with affective disorders have training in cognitive therapy. It is argued that specialist services should be extended to other important areas such as patients with psychoses, affective disorders and behavioural disorders, and sectorisation would remain only for those socio-demographic areas unable to sustain specialist services. Sub-specialisation will improve the popularity of general adult psychiatry by offering a more expert service to patients and greater professional satisfaction to practitioners.

These proposals are aimed both at improving recruitment and retaining an enthusiastic and knowledgeable workforce of consultants. This would be of great benefit to future patients.

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