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OF THE

ROYAL COLLEGE OF PSYCHIATRISTS

COLLEGE NEWS

FUTURE FOR BRITISH PSYCHIATRY

Council discusses College role

(from a correspondent)

The President of the College (Professor Desmond Pond) called a two-day meeting of Council Members for 8 and 9 February for informal discussion of trends in psychiatric practice in the NHS, and what the College should be doing to shape them. Some of the trends were dictated by population changes, for example, the great increase in the number of old people and the survival of the mentally handicapped, others by swings in popular belief. For example, the mentally handicapped were now being seen as an educational rather than a medical problem. This tendency to oversimplify problems to extremes of black or white (a man is either bad and should be in prison or mad and should be in hospital) was promoted by the growth of separate professions such as clinical psychology which wanted a place in the sun independent of the doctor. Such separatism in turn derived partly from a world-wide trend against the expert knowledge of the specialist ('élitism') and from a general loss of respect for the old professions such as medicine.

The NHS itself was a new force coming between doctor and patient. It inhibited alternative thought and practice and discouraged self-help. Amidst a plethora of committees and working parties it was difficult to see who actually took decisions. How in

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this system could there be more necessary local independence and a diversity of experiment to meet new needs?

Discussions ranged under the four general headings of education, manpower, research, and College organization and public relations.

EDUCATION AND TRAINING

Three aspects were examined: the overseas graduate trainee, the psychiatric training of general practitioners, and the continuing education of consultants, with medical audit.

There are about 2,500 psychiatric posts in adult mental illness in England and Wales, about 1,500 of them training posts. The contribution of overseas graduates was substantial: in 1977 approximately one-third of senior registrars, two-thirds of registrars, and nearly three-fifths of SHOs came from abroad. Some of these people will make their careers here, others come for training and then move abroad again (and incidentally, nearly one-quarter of the College's membership now works outside Britain). The overseas graduate inevitably arrived here with cultural and language difficulties, and was more likely to get a poor job with less educational opportunity. There was still a great deal the College had to do about this. One possibility was to have fewer training hospitals, and for every registrar to spend part of his time in an academic centre. Perhaps trainees who intended to return to their own countries should have a training more adapted to the problems and conditions of work at home. Was there a place for a lower grade examination—a certificate, or a re-vamped diploma of psychological medicine—for those who would not stay here three years, or who could not pass the MRCPsych? Hitherto most overseas trainees had come from India, but this might well change, possibly with a partial replacement from elsewhere, e.g. by EEC graduates.

General Practice

There are about 26,000 general practitioners, and last year there were nearly 1,300 doctors in their final year of GP training. The Government has made a three-year period of training obligatory, and psychiatry is likely to be six months of that time for most trainees, requiring a maximum of 600 training posts. What should be the content of that training? The general practitioner's work was different from that of the psychiatric specialist. Perhaps he needed encouragement of psychological awareness in dealing with patients, experience of the complex social medicine of psychogeriatrics, instruction in family therapy and brief psychotherapy and the use of psychotropic drugs. He wasn't being made into a substitute specialist, and great care would be needed to see that his training post did not simply become a source of easy labour to keep the hospitals going or a drain on the interest and experience of the trainee psychiatrist's post. As for the latter, it seemed likely that in the future general psychiatrists would also have special training in some of the specialties, rather than leaving these fields to the super-specialist. Psychogeriatrics, forensic work, drug dependence, mental handicap, should perhaps be everybody's task, if only because with recruitment to psychiatry in general falling this was the only way the work would get done. We could concede behaviour therapy with pleasure to psychologists or specialist nurses, and rearrange our overall work burden to meet the new needs of assessment and management of patients, and training of others.

Medical Audit

Both Government and public were increasingly concerned about quality of care. They wanted to feel that the NHS gave a high standard of medical care and treatment, that doctors were always competent and up-to-date, and that ignorance, carelessness and inhumanity would be eliminated where they existed. The College through its meetings and publications already helped to educate the consultant further (though few took the study leave the NHS now allows) and issued statements about standards of good practice. In addition, the visits of its approval teams to every hospital were a stimulus to improvements and in some cases involved some assessment of consultant work. The College stood for good standards of training and practice, but if it did not do more to encourage self-criticism and improvement, outsiders would step in and impose controls, as they were doing in the USA.

Medical audit covered not only the assessment of individuals but the evaluation of procedures. There could be an inquiry into how suicides came about in hospital, in case they could be prevented; or comparison of relapse rates among the patients of different teams; or study in an area of the way ECT was carried out. The Education Committee would have to start a serious review of how the quality of work could be improved, and this might well throw up organizational or financial difficulties in the NHS. We should not worry over how the hospital service was to keep going, however. That was primarily for the DHSS; we should put high standards of work first.

MANPOWER

Data and calculations were presented to show that we need many more consultants to achieve the standards the DHSS wants to see, and that some areas

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(notably Trent and West Midlands) fall far behind even the present national average. Yet at the same time a surprising number of posts are unfilled, either because they are unattractive in their lack of ancillary support, or because of extraordinary delays in advertising them. It looked as if over 10 per cent of all UK medical students would have to opt for psychiatry if the College's plans for staffing were to become reality. Of course the picture would be different if a career grade non-consultant post was introduced, if hospitals were divided into training and non-training centres, and if some of the specialists were absorbed by the generalists. It was also true that in the past many psychiatrists had come into the specialty indirectly—from some other specialty, or from domestic life in the case of women, or from the Services, and this late arrival was not allowed for in the calculations. Nor was the possibility that the nature of some of the psychiatrist's work might change.

RESEARCH

Research in the wide sense embraces not only additions to knowledge which modify psychiatric practice but also project work, the writing of a critical review and the attempt to plan a study which benefits primarily the student who undertakes it. Many regarded it in the latter sense as an essential part of the intellectual training of a consultant. Recruitment to psychiatry might decline if there were no research, no intellectual liveliness, in the field. Yet the evidence was that fewer young psychiatrists were undertaking projects—they could get good jobs without—and there was a lack of encouragement from existing research units and academic centres. One of the College's duties was to encourage research, and perhaps more should be done through the Divisions. It awarded prizes, it was holding a special trainees' research meeting, it had tried the research option for the MRCPsych. (not a success). It could offer more advice, possibly through clinical tutors or local research advisers. It was now embarking on its first major research project, on the use of ECT, after sponsoring small surveys of barbiturate use and of psychosurgery.

This represented the second reason, after education, why the College had to be concerned about research. It is, after all, a learned body, it has a standing to maintain, and its influence in medicine and in the world can only increase if it is seen to be usefully expanding knowledge. It need not compete with the universities. Its special opportunity arises because it is a national organization in contact with psychiatrists all over, making surveys and multicentre collaborative trials that much easier. Should a research office become a permanent part of College organization, to channel information on grants and the collection of research funds and on the guidance of trainees, and as a nucleus around which to build special research programmes?

COLLEGE ORGANIZATION

The College is growing at the rate of about 300 members a year. At present there are nearly 4,000 of them, and just over 900 fellows, which with 1,100 inceptors plus affiliates makes a total of about 6,000 people, about one-fifth of whom are overseas. There are 370 in the Scottish Division, 250 in the Irish, 136 in the Welsh, and the seven English Divisions range from 274 (East Anglian) to 656 (Southern), the latter being partly London south of the Thames and partly rural and coastal. The College was also organized not geographically but by special interest into Sections—psychotherapy (2,111), psychogeriatric (273), child and adolescent (1,350) and so on. The Council, 64 strong, was composed of representatives of both Divisions and Sections, usually a Member and a Fellow elected from each. One question was whether the Divisions were now meaningfully drawn, and whether the College's work was better done through them or through the special interest Sections.

Committees and working parties had multiplied and grown: the Library Committee totalled 30, the Education Committee 49 members, and there were at least 17 business groups apart from the standing committees. The time had come to recognize that so many and such big groups created a great deal of secretarial work, and the College now spent about two-thirds of the annual subscription on salaries and employed the equivalent of 20 full-time people at Belgrave Square. Should there be some devolution to the Divisions, and pruning of what went on at headquarters?

One field of work where the College was perhaps not doing enough was in Public Relations. There were many pressure groups at the present time with an anti-psychiatric bias or a misunderstanding of psychiatric practice and what the College stood for, and they tended to get newspaper space, TV attention, and the ear of MPs. Something was already done, but not enough to hold a fair balance. It was necessary to examine in detail the role of Divisions in this, and what central organization was needed. There had to be a core of the membership who were concerned and bringing ideas and skills to the problems. A professional public relations officer, whether part-or whole-time, was a very expensive person, and would do little good until there was a sound base of College interest and enthusiasm.

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