three years. Consultant staffing entered a critical phase.

There was increasing uncertainty nationally about the future direction of mental handicap services. Some health authorities became noticeably slow to fill consultant vacancies in mental handicap. Hospital bed numbers for mental handicap in the Yorkshire region had risen to a peak of 4,068 in 1966 and then fallen, with 3,872 in 1973, 3,642 in 1976, 3,450 in 1980, 3,125 in 1983, and 2,503 in 1986.

As the hospitals were running down it was thought that fewer consultants would be needed. The fallacy of such claims was later realised. Because there were fewer mentally handicapped people in hospitals it did not mean that the number of mentally handicapped people in the population was any less than it had been. Maintaining mentally handicapped people in the community often calls for more time and attention than keeping them in a hospital ward.

Health authorities tended to assume that a shortage of suitable candidates for consultant posts in mental handicap was a reason for not advertising them. In practice the posts that were advertised were eventually filled. Delays resulted in two senior registrars who had trained for three years in the region obtaining consultant appointments outside Yorkshire.

A move towards more flexible staffing began in 1983 with a joint post in mental illness and mental handicap at Huddersfield. Consultant posts combining three sessions in mental handicap with mental illness were introduced for Calderdale in 1987 and Harrogate in 1988. Full-time vacancies were filled at Pontefract in 1983, York in 1984, and Hull in 1988. After much discussion and procrastination a consultant post with five service sessions and five sessions as senior lecturer in mental handicap was finally filled at Leeds in 1987.

In November 1988 the Yorkshire region had eight full-time posts, one joint appointment and two special interest posts in mental handicap. Leeds and Bradford had fewer consultants than a decade ago. A third consultant post, full-time, is promised for West Leeds. More joint and special interest appointments are likely to be seen in districts with less than 200,000 population.

Where there is only one specialist to cover mental handicap in a health district the consultant might have a feeling of working in isolation. The need to have opportunities for consultants in mental handicap to keep in touch with their colleagues will continue to be important in the future. The presence of a regional association is one way of meeting this need.

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Foreign report

Psychiatry in Canada

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There are two episodes which remain in my mind from the first night I was on call at the Clarke Institute of Psychiatry, Toronto in 1980. The first person I assessed in the Emergency Room was a young university student in her early twenties who had been reading "Jung" and urgently needed to discuss "archetypes and the animus"; the second incident some hours later involved a middle aged man who was manic on admission and responded rapidly to the 10 mg of haloperidol I administered intravenously in front of a silent and, as I later discovered, astonished night nurse and junior resident. The patient settled rapidly and my unorthodox treatment was a talking point for several weeks. These two vignettes alerted me to the fact that things were different here. No-one had ever used intravenous neuroleptics in Toronto at that time, and equally no-one in Newcastle on Tyne, which I had left only two weeks earlier, would consider the casualty department of the Royal

Victoria Infirmary a necessary stop as they waded through Jung.

Over the first year I completed a seemingly endless myriad of documentation to be able to sit the Canadian Fellowship Examination (a multiple choice exam known more for its devotion to the esoteric than the practical aspects of psychiatry; followed by a supervised psychiatric interview) and the Licenciate of the Medical Council of Canada – LMCC. In recent years a further eligibility exam has also been added – the Medical Council of Canada Evaluating Examination (MCCEE). On completion of this examination, one requires a Canadian or US internship (pre-registration training) before a general licence is granted in Ontario, which would enable an individual to train in a postgraduate programme such as psychiatry at one of the five Ontario medical schools. Mercifully I was spared much of this, and after my immigration status was settled, it was time to take stock of my future.

In a city like Toronto, where approximately 30 certified psychiatrists begin a new psychiatric practice each year, the majority of graduates will begin a practice career as psychotherapists, usually with a psychodynamic orientation. Since the health care system is mainly funded on a fee for service basis, this allows private practitioners to dictate their hours of practice and hence their income. For a substantial number of private psychiatrists, the use of pharmacology is not part of their psychiatric practice and thus most hospital treated patients would not be accepted for follow-up management.

For those who decide to work in a hospital setting, a minority become salaried employees within the Provincial Psychiatric Hospital System. This type of practice is the closest to a UK 'mental hospital' appointment, and often allows psychiatrists who have not obtained all their Canadian qualifications to work with a restricted licence. Elsewhere, psychiatrists in general hospitals work in a university affiliated hospital, while other non teaching hospitals are staffed by private psychiatrists who usually also maintain private offices outside of the hospital. After a brief sampling of psychiatry in a non teaching setting I chose to work within the University System.

Eight years later, I visited the Institute of Psychiatry in London and had the opportunity to reflect on the relative merits of being a psychiatrist on both sides of the Atlantic.

For the past six years I have been a staff psychiatrist (consultant) with a university appointment at a large Toronto Teaching Hospital. In this setting there is a clear expectation that, in addition to regular clinical duties, teaching, research and administration are all part of the job, although most people develop expertise in one or two of these three additional areas.

Clinical practice

For me, clinical practice involves responsibility for ten in-patients within a specialised clinical unit (treating patients with eating disorders and affective disorders) as well as a significant out-patient case load which reflects both clinical and research interests. Unlike the UK we do not have a senior registrar level, hence contact between staff psychiatrist (consultant), resident (who may be anywhere from first to fourth year in the level of training) and patient is frequent. I would expect to be directly involved in patient care for about 30 hours per week, including ward rounds, resident supervision and direct patient contact.

Teaching

The residency training programme requires a four year rotation which must include at least one year in a general hospital setting, six months in child psychiatry, six months in the care of chronic psychotic patients, as well as a "significant supervised experience in psychogeriatrics and consultation-liaison psychiatry". Since the majority of the 30 graduates per year from the University of Toronto programme will work in private practice doing mainly psychotherapy, there is keen competition among senior residents for 'the best' psychotherapy supervisors. Case supervision is an integral part of resident teaching and ranges from a minimum of one to three or four hours per week, depending on staff and resident interests. Since the final part of the Fellowship examination in psychiatry includes a clinical interview in the company of one of the two examiners, observed clinical interviews are an important part of supervision. For some time there has been an ongoing debate about the most appropriate way to approach case formulation. In the past five years, there has been an increasing emphasis on biological psychiatry and the accurate description of clinical syndromes (usually based on DSM-III criteria, although for statistical purposes Canada still adheres to the ICD). This has left the role of psychodynamic formulation unclear; nevertheless, there is a broad consensus that the individual patient and his or her illness should be described in terms of biological, psychological and social factors. As a general rule there is a more formal approach to teaching, with courses on teaching skills for the teachers becoming increasingly popular.

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Research

Developing a research career can be difficult within the Canadian system. Since the majority of clinical researchers are obliged to generate a significant portion of their income from direct services to patients, there is usually a continuing compromise between clinical and research time. In contrast to the US or UK, most Canadian granting agencies do not pay salaries to principal investigators. This is not the case, however, in provincial psychiatric hospitals where physicians are salaried, and may hold a specific research appointment. Agencies likely to support psychiatric research in Toronto include the Ontario Mental Health Foundation, the Medical Research Council and Health and Welfare Canada. Unfortunately, since it lacks a national training centre for clinical research, such as the National Institute of Mental Health (NIMH) in the US, psychiatrists in Canada who want higher training usually look to the US for such experience. In recent years individual centres in Toronto have published innovative research in affective disorders, schizophrenia, sleep and eating disorders.

Administration

The per capita cost of health care in Canada is approximately double that in the UK, and Ontario has the highest rate for institutional care within Canada. Not surprisingly, cost containment has become a major issue in recent years, as the Ministry of Health becomes more committed to balanced budgets. The response of hospital administration has been to place more onus on individual departments to cut costs. At Toronto General Hospital this has led to such innovative concepts as a hospital-run pizzaria and charges to physicians for office rental – in contrast to consultants within the National Health Service, for whom such costs are absorbed within the system. Because of the high cost of a fee for service system, a number of alternative systems are being evaluated. These include the concept of Health Maintenance Organisations (HMOs) which involve a capitation system to provide comprehensive health care, whereby 'volunteers' sign up to receive centralised care.

The UK revisited

When I arrived at the 'Institute' I wondered how much the British system would have changed after my eight year exile. Would I be able to master the elusive technique of getting an outside line on a hospital telephone? Would there be bacon sandwiches in the canteen at half past ten and would out-patient clinics still be as overcrowded and tardy in their operation? While the phones still extracted their pound of flesh, other things had changed. Personal computers were prominent in most departments and statistical packages were a more frequent topic of conversation than the English weather. One industrious colleague even admitted to putting in a couple of hours work in the early mornings before leaving for the Institute, a relatively common practice among my Toronto colleagues. But one tradition had clearly not changed – professorial rounds. The direct exposure of the medical student or junior registrar to such a public grilling would be considered too insensitive across the Atlantic, yet I still recall information extracted from me under similar circumstances ten or more years later. At this point I must concede that, since my visit was confined to the Institute of Psychiatry and the Maudsley Hospital, I am not in a position to say how much these observations could be generalised to the rest of the UK.

Non-professional life in Toronto

So far I have only considered the professional aspects of life in Toronto for the psychiatrist. Now, I would like to touch briefly on family and social aspects of the city. Toronto continues to grow at a rapid pace. Up to 1,000 people per week are said to be moving to the Toronto region from other parts of Canada. Major building projects, particularly condominiums within the city and new housing subdivisions up to 50 miles North and East of the city are springing up. House prices have increased disproportionately to the rest of Canada. For example, a small three bedroom dwelling in 1978 which cost $55,000 would cost $230,000 in 1988 (*Toronto Star*, 6 August 1988). The city is known for its cleanliness, efficient and relatively inexpensive single fare transit system, and more recently for an enriched cosmopolitan flavour in its shops and restaurants. Generally the public (i.e. government funded) school system is well regarded and active parental participation is encouraged, although more recently there has been an increase in the demand for and the number of private schools within the city.

Canadians are currently preoccupied with the political and economic implications of our Free Trade Agreement with the United States, and the more environmentally conscious lobby for increasing action on acid rain and its effect on Ontario's strikingly beautiful lake areas. As the 'global village' becomes smaller I think the differences in life style, availability of consumer goods and personal attitudes become less apparent between international cities whether one lives in Melbourne, Los Angeles, Toronto or London.