Consultant Norms in General Psychiatry

PETER KENNEDY, Secretary, Manpower Committee

The College's Manpower Committee, chaired by Dr Fiona Caldicott, has recently debated the case for setting new norms for general psychiatrists to meet increased clinical demand caused by changing expectations of community care, the new Mental Health Act and the rising numbers of elderly mentally ill and patients with alcohol and drug problems. One view was that such an exercise would be a waste of time, owing to uncertainties about the implementation of 'Short' and also because many districts have not yet reached the norm of one (whole-time equivalent) consultant to 40,000 population agreed with the Department of Health in 1975. It was agreed that the Manpower Committee should first of all try to help consultants in undermanned districts to overcome obstacles frustrating local initiatives to increase the establishment of general psychiatrists. Letters should be addressed to Dr Caldicott at the College address.

The argument in favour of revising norms was that unless the profession advises on what the changing service requires of consultants, district and unit general managers will decide for themselves. It is not impossible that a manager, unhappy with consultants who are poor representatives of the specialty, would prefer to staff the mental health service with less expensive community psychiatric nurses. If 'Griffiths' leads to fewer manpower controls being established by the DHSS, there will be even greater need for psychiatrists to explain the particular skills they have that others in the multidisciplinary team do not, and the level of consultant manpower required to ensure an adequate service to patients in a district. But just asking for more consultants and plucking a new norm figure out of the air will not do. A realistic appraisal must be made of the additional tasks now expected of general psychiatrists. There will be subtractions as well. Over the last decade, many tasks have been handed over to psychologists, GPs or community psychiatric nurses who are able to carry them out just as competently. And we should not start with the assumption that the new Mental Health Act has increased our work, for some hospitals are noting a reduction in compulsory orders and in the numbers of ECT treatments administered by psychiatrists. Social workers and volunteers have taken over routine tasks in assessing and counselling drug and alcohol abusers. There might be some surprises when workloads are accurately calculated.

Yet it is not at all easy to discover what general psychiatrists are doing, even in the broadest terms of sessional time devoted to special interests/responsibilities. A recent pilot survey carried out by the Manpower Committee found that over half of general psychiatrists in two regions had special responsibilities with sessional time allocated. In the majority this had been decided after appointment, and so it was not reflected at all in the consultant manpower statistics obtained by the DHSS from regions showing the numbers of consultants in mental illness (adult). True, some of the College's special interest groups and specialty committees in the dependencies, forensic psychiatry, the psychiatry of old age and psychotherapy, have collected and made available such data. But their efforts have not been co-ordinated and operational definitions have not been the same, so that the results do not, when put together, give a comprehensive and consistent picture. Indeed, inconsistencies are such that these surveys are in danger of being dismissed because of their inaccuracies. There is an immediate need for co-ordination of efforts, if only to give senior registrars a better indication of the kind of consultant posts to prepare for. Perhaps also, in studying the trend towards specialization of general psychiatrists, we should highlight that part of the job which planners of services must be persuaded to value highly. That is the element of leadership shown by consultants in the past and needed in the future to develop new methods of care based on understanding increasingly specialized research, to apply new ideas, monitor effectiveness and with clinical budgeting on the horizon, to do so at the right price.

The Manpower Committee concluded its debate with agreement to explore further a proposal made by the Dean, Dr Birley. He suggested that advice should be sought on how to carry out a *work study* on the activities of general psychiatrists, so that the elements of the job can be described, the time necessary for carrying out essential tasks can be estimated, and manpower numbers then calculated in relation to the volume of demand in different situations, e.g. urban versus rural districts and teaching versus non-teaching districts. On this basis credible norms for consultant manpower in general psychiatry might be arrived at. Despite the considerable practical difficulties, setting new norms seems preferable to being pawns!

Any comments which members would like to contribute to the debate will be both appreciated and considered. They should be forwarded to me at the College.

The Merck, Sharp and Dohme Prize

The winner of the 1985 Merck, Sharp and Dohme Prize in Psychiatry (East Anglia) was Dr Tom Dening, Registrar, Fulbourn Hospital, Cambridge, with an entry on 'Blinking and Essential Blepharospasm'; no second Prize was awarded this year.

The Academic Department of Psychiatry announces that the competition has now been opened for the 1986 MSD Prize; First Prize, £150; and Second Prize, £40. Psychiatric trainees working in the East Anglian Region are elegible. For details please contact; Mrs M. A. Coburn, PGME Secretary, Fulbourn Hospital, Cambridge CB1 5EF.

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