

Other necessary details of the service

1. The psychiatric service

(a) The catchment area (whether or not coterminous with the old age psychiatry catchment area); (b) number of acute and long-stay beds; (c) number of sessions of consultant time; (d) number of trainees; (e) number of clinical assistant sessions; (f) number of day hospital places and (g) number of community psychiatric nurses.

2. The geriatric service

(a) The catchment area (whether or not coterminous with the psychiatric service for the elderly); (b) total number of consultant sessions; (c) consultant sessions available to the psychiatric service for the elderly; (d) total number of geriatric beds; (e) number of geriatric beds on an acute hospital site and (f) number of geriatric day hospital places.

3. Social services

(a) The area served (whether or not coterminous with the health services and the size of the population over 65); (b) number of Part 3 residential places and day centre places; (c) number of EMI home places and EMI day places; (d) whether or not any personnel are available with special expertise relating to the elderly and the proposed social work input into the psychiatric service for the elderly; (e) number of places available in private nursing homes and (f) details of sheltered housing.

4. Administration

(a) Details of the local cogwheel organization and (b) is there a regional adviser or advisory group in psychiatry of the elderly?

Summary

For a district service with a total population of 200,000 and 30,000 over the age of 65 the following are required:

Functional illness: (i) 15 acute beds; (ii) 5 new long-stay beds; (iii) 20 day places.

Dementia service: (i) psychogeriatric unit—30 beds; (ii) long-stay—75 to 90 beds; (iii) day places—90.

Consultant time: 15 sessions. In a teaching area there should be 50 per cent increase in consultant time.

Non-consultant medical staff: (i) trainees 25 per cent share of total in psychiatry; (ii) senior registrar 25 per cent share of total in psychiatry; (iii) clinical assistant according to availability and deployment.

Other staff: 1.5 to 3 secretaries for the functional illness service and the psychogeriatric unit. Additional secretarial time for the dementia day hospital. Two to 6 community psychiatric nurses.

The facilities described above are not ideal but are those required to establish a credible psychiatric service for the elderly. Shortage of money at the present time means that promises made in job descriptions are unlikely to be fulfilled in short term, and therefore a post should not be approved unless facilities are to be immediately available. Health authorities would be unlikely to create posts for surgeons without beds and operating and anaesthetic facilities. They must be made aware that a psychiatric service likewise cannot operate without a basic provision.

Overseas Trainees in Psychiatry*

By SURYA BHATE, Chairman, Overseas Trainees Committee

For decades doctors have been migrating from developing to developed countries. Principal beneficiaries of this trend have been the USA and UK, though similar trends have been evident in France (Algerian doctors) and to a smaller extent in Germany. Few doctors from developed countries go to developing ones for training (or to train), so the flow of migration is virtually one way. In the UK concern has been expressed about the competence (technical as well as the ability to converse in English) of immigrant doctors, leading to rather confused and at times acrimonious exchange of views. Until recently there has not been any attempt by governmental agencies or professional bodies to look at various aspects of the immigration of physicians and its effects.

*The views expressed are the author's own and do not necessarily reflect those of the Committee.

Overseas doctors have been coming to the UK for several decades. Many trainees have overcome enormous obstacles to come to this country for further training. It has become apparent that few doctors return to their country of origin after further training, most preferring to stay in the UK and some going to the USA. This has led to a complex situation, often contributed to by a lack of clear-cut policies on the part of successive governments.

Often immigrant doctors have arrived and stayed in response to employment opportunities and to the extent to which overall demand is or is not met by British graduates. Thus, the immigrant doctors may be seen as responding, in market terms, to demand and supply. Jobs are offered, doctors are available, and migration follows. The effect of this policy has been to employ overseas doctors predominantly in shortage, undersubscribed and unpopular

specialties, where posts have not been taken by British graduates.

*Percentage of overseas-born doctors (September, 1977)**

	Sen			
	Consultants	Registrars	Registrars	SHOs
Mental illness	21	35	64	56
Mental handicap	27	73	88	71

*(*BMJ*, 1979)

Overseas trainees broadly fall into two groups: important, but small (numerically), are the trainees who arrive for training in psychiatry at several centres, including the Institute of Psychiatry and the Department of Psychiatry in Edinburgh. Leff (1980) has described this group. However, the large majority of overseas trainees belong to the other group. Whilst the members of the former group are often sponsored by governmental agencies or Commonwealth scholarships etc, the latter group arrive under their own steam. The decision to come to the UK is often a long and continuous consideration in the minds of doctors, while training in their respective countries. Once the decision is made, the doctor arrives in the UK and often has to change his original plans for training in a particular specialty. He has to respond to market forces and tends to fill a residual role in the employment market. Failure of British medical schools to attract more than 3 per cent of its graduates (Brook, 1976) to opt for training in psychiatry points to further dependence on overseas graduates to fill training posts in psychiatry. It is essential for these, and other reasons, that attempts should be made to further research into the background, aspirations, difficulties and problems of overseas trainees working in psychiatry.

Some areas of difficulty

Family and children: There is some evidence that different members of the family may be subjected to different kinds of stresses. The husband (or wife) may be under pressure to succeed but may find himself in a job which attracts lower status and authority (compared to his country of origin).

Wives may have particular difficulty in adjusting to changes in housing, climate and language. This may be further complicated by lack of availability of servants and other accustomed supports. Children may have to learn a new language and cope with a new education system. The initial comfort of hospital-housing may in the long term turn out to be disadvantageous as it often inhibits assimilation.

The term 'culture shock' is frequently used, but is poorly defined. Cox (1977) describes it as a normal psychological adjustment to an abrupt transition from one culture to another, which may need to be distinguished from the common psychiatric symptoms. Doctors are not immune to psychological stresses, and in the early period of the doctor's arrival senior colleagues may need to keep this possibility in mind.

Training and examination performance: A substantial majority of overseas trainees obtain posts and train in non-university-affiliated hospitals which are less prestigious. They often begin training in a different cultural, professional and educational milieu from the average UK graduate. This has obvious implications. Overseas trainees' professional and/or cultural competence is of overriding importance. It is often a critical gateway to other forms of learning. The trainee who is not perceived as a 'full' trainee may be given fewer opportunities for informal discussions and consultations, and therefore less clinical responsibility. Cumulatively, a less culturally competent doctor may come to receive less than optimal educational experience.

Poor performance of overseas graduates in examinations has been a cause of increasing concern. Mahapatra and Hamilton (1974) have shown that language difficulties alone are not an adequate explanation for the high failure rate, and a preliminary analysis of first year departmental examinations at Edinburgh showed similar poor performance by overseas psychiatry trainees (Cox, 1977).

Language/cultural competence: Introduction of TRAB, now mellowed to PLAB (by the GMC) attempts to establish the minimal language competence of overseas doctors whose mother-tongue is not English. There is, however, some suggestion that 'trainers' may see the problems in terms of language and cultural difficulties while the trainees deny these difficulties and see the problem areas very much in terms of prejudice (Creed—personal communication).

Where help and advice can be sought and expected

Consultants and psychiatric tutors bear special responsibility in this area. Overseas trainees may need to have explained to them some aspects of British culture and tradition. For example, method of greeting, traditions of hospitality, current trends in psychosexual encounters. An attempt to give (and perhaps gain) insight into the irrationality of prejudice may go a long way to help the trainee.

The Grubb Institute report (1978) on overseas students has suggested that, in each centre of higher education, there should be a designated academic tutor with a particular responsibility for overseas students. A research survey of the overseas nurses by the Royal College of Nursing has highlighted the difficulty of 'trainees' seeking counselling and advice from superiors who are the same people with authority affecting their future careers.

The recently published second edition of the *Handbook for Inceptors and Trainees in Psychiatry* provides useful and essential information and is a must for doctors thinking of a career in psychiatry.

Acknowledgments

I am grateful to members of the Overseas Trainees Committee for their comments, and to Dr Bewley and Dr Cox for reading and correcting the draft manuscript.

REFERENCES

- BROOK, P. (1976) Where do psychiatrists come from? The influence of United Kingdom Medical Schools on the choice of psychiatry as a career. *British Journal of Psychiatry*, **128**, 313-17.
- COX, J. L. (1977) Aspects of transcultural psychiatry. *British Journal of Psychiatry*, **130**, 211-21.
- LEFF, J. (1980) Overseas trainees in psychiatry. *British Journal of Psychiatry*, **137**, 288-89.
- MAHAPATRA, S. B. & HAMILTON, M. (1974) Examinations for foreign psychiatrists: problems of language. *British Journal of Medical Education*, **8**, 271-74.
- REED, B., HUTTON, J. & BAZALGETTA, J. (1978) *Freedom to Study—Requirements of Overseas Students in the UK*. Overseas Students Trust, London: Grubb Institute.
- REPORT OF COUNCIL WORKING PARTY (1979) Medical manpower: Staffing and training requirements. *British Medical Journal*, *i*, 1365-76.
- STEVENS, R., GORDON, L. & STEPHEN, M. (1978). *The Alien Doctors: Foreign Medical Graduates in American Hospitals*. John Wiley.

Manpower 1982-1983

Bids for new posts for 1982-83 will be decided by Regional Authorities on the advice of Regional Manpower Committees within the next few months on the basis of guidelines formulated and issued by the DHSS. There seems little likelihood that cash limits will be significantly eased by 1982-83, and the case for psychiatry will have to be argued in face of a greater degree of consultant expansion to be allowed in the support specialties—e.g., anaesthetics, radiology, and unlimited expansion, as far as central approval is concerned, in general medicine, general surgery, and obstetrics and gynaecology. It may be expected that the non-metropolitan Regions will be better placed financially to meet consultant expansion, so that while on average two to three adult mental illness consultant posts will be permitted in each Region, Regions with resources may be encouraged to bid above this average, as preference will normally be given to Regions with the lowest ratio of establishment to population. The same principle would apply in child and adolescent psychiatry where on average one post per Region may be allowed. Only two new consultant posts in mental handicap will be created in the year in England and Wales. Applications for forensic psychiatry posts for regional secure units will be treated sympathetically, and, while there is no limit proposed for psychotherapy posts, the small number of senior registrars who will have completed training suggests that few bids are anticipated for this specialty.

Senior registrar and registrar posts are not likely to be approved in any of the psychiatric specialties. The high percentage of unfilled posts in mental handicap and child and adolescent psychiatry would suggest that the best use may not be being made of established posts in these specialties.

Since until they are, consultant expansion will be limited, serious local consideration may have to be given to reallocating senior registrar posts within a Region, perhaps with reverse compensatory reallocation of registrar or SHO posts. As far as psychotherapy is concerned, it would seem that the case for senior registrar expansion can only be made when consultant bids exceed the number of trained senior registrars.

Senior house officer, clinical assistant, and hospital practitioner posts will remain matters for local decision. Registrar, senior registrar, consultant and personal applications for appointment to the medical assistant grade will continue to be considered centrally. In general, all bids for extra medical staff are initiated at District level. Those concerned with medical assistant and consultant posts will be referred from Area to Region when the advice of the Regional Manpower Committee is obtained. Regional bids are referred to the Central Manpower Committee for advice, while the Department formally issues authorizations. The junior hospital doctor representatives on the Central Manpower Committee may exercise a veto on medical assistant approvals; they often express anxiety that the creation of medical assistant posts may prevent an increase of consultant posts. It should be remembered that the post vacated by a medical assistant on appointment to that grade is not lost to establishment, while a post of medical assistant vacated by its personal holder may be upgraded to the consultant grade.

ASHLEY ROBIN, *Chairman*
FIONA CALDICOTT, *Secretary*
Manpower Committee

EXAMINATIONS—AUTUMN 1981

The next MRCPsych Examinations will take place on the following dates:

Preliminary Test—2 September 1981. (Closing date for receipt of entries—1 July 1981)

Membership Examination—28 October 1981 (written papers); 2 to 5 November 1981 (clinical and orals). (Closing date for receipt of entries—5 August 1981)

The entry fees are £40 and £65 respectively. Late or

incomplete entries are not accepted. The College does not give exemption from any part of the examinations. Candidates are reminded that they must pass the Membership Examination within five years of passing the Preliminary Test.

Details and entry forms are available from the Examinations Secretary at the College.