age, drug dependence and alcoholism. The same ratio was also mentioned in a DHSS paper entitled *Manpower Priorities of Special Interests in General Psychiatry* (1975).

However, in the College's Document *Providing a District Service for General Psychiatry, its Special Interests and Related Specialties: Medical Manpower Priorities*, published in the *Bulletin*, December 1977, recommendations were made for long-term goals exceeding the DHSS's, and amounting to one whole-time equivalent consultant per 25,000 population. The Document included the following Table setting out the College's views as to how consultant sessions might be used in an 'average' District in the immediate future, and the College's long-term recommendations:

Special interest	No of sessions per week per 200,000 population (average district)	
	Column 1 Immediate needs	Column 2 Long-term goals
Forensic Psychiatry	2	5*
Psychotherapy	5	11
Dependences		
i. Drugs	1	1
ii. Alcohol	3	3
Psychiatry of Old Age	11	17
General Psychiatry	33	51
	55	88

* Includes allowance for Special Hospitals of 1.5 sessions.

In the DHSS's 1975 *Manpower Priorities* paper, it was suggested that there might be a case for a higher consultant to population ratio in 'Teaching Districts', and in subsequent preparatory discussions the Department recorded the view that bids from such Districts would be likely to be accepted in excess of those strictly allowed nationally. The Department, however, drew attention to the practical problems involved.

In the circumstances it was agreed that these problems should be considered by a joint Working Party of the College and the Association of University Teachers of Psychiatry (AUTP). The Report of a survey presented to this Working Party is appended as Document 2.

Further discussions were held between the two bodies, and the following recommendations were agreed upon:

1. In Teaching Hospitals the College's long-term aim should be accepted as an interim goal. Where the Teaching Hospital provides comprehensive services for its District there should be one whole-time equivalent consultant per 25,000 population for general patient care, i.e. 1·6 times that for District services elsewhere. Where the Teaching Hospital does not provide a comprehensive service but special facilities are available, bids for consultant posts should be presented in terms of work load multiplied by a factor of 1·6 for comparison with an 'average' District.

2. As the longer-term goal to be achieved in association with those for 'average' Districts (Table, Column 2), Teaching Hospitals should have an establishment of one whole-time equivalent consultant per 16,000 population. (This recommendation is made on the basis of current experience in providing a satisfactory clinical service for teaching and research, and is in keeping with the findings of the Working Party.)

3. It is for the Area (Teaching) Health Authorities to decide the local priorities for consultant posts to be filled.

It is hoped that this Document will serve as a background for the future planning of psychiatric services in the Teaching Health Areas.

2. REPORT TO THE WORKING PARTY*

By Gerald Russell, Kenneth Granville-Grossman and Sydney Brandon

The Working Party was set up to consider the question posed by the DHSS as to whether there should be a 'teaching increment' to the consultant target, i.e. should Districts with special teaching responsibilities have more consultants than similar 'non-teaching' Districts?

The relevant arguments were stated as follows in the DHSS Manpower Priorities Document (1975):

'13. The arguments for a higher consultant to population ratio in Districts with special teaching responsibilities are that:

(i) consultants in teaching hospitals have less time to devote to direct patient care,

(ii) a teaching hospital accepts referrals,

* Based on a survey conducted in September 1976.

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particularly of patients presenting special problems from outside its District.

(i) is an argument for using a higher ratio, and

(ii) an argument for applying it to a 'catchment' or 'notional' rather than District population.

14. However, in considering what this increment should be there are problems in assessing:

(a) how much more time consultants in teaching hospitals devote to teaching than those in ordinary hospitals or units,

(b) the corresponding contribution to patient care made by academic staff of associated University departments,

(c) the extent to which the teaching hospital is providing a district service and to which it is integrated with the relevant 'division' of the associated mental hospital.

At this stage a word of caution is necessary. It is essential to avoid any divisiveness that would arise from considering teaching hospital departments of psychiatry as 'special cases' in such a way as to cause resentment among our professional colleagues. The Working Party readily reached the agreement that the implementation of any recommendations for 'a teaching increment' or any other supplements to 'teaching' hospitals should not interfere with plans to improve the staff of 'non-teaching' hospitals. It is recognized that most psychiatric units and hospitals undertake a great deal of teaching, at least at a postgraduate level; however, the official terminology is followed, in order to identify the departments of psychiatry which teach undergraduates as a primary responsibility and whose functions are the principal subject of this report.

Available sources of information

In between meetings of the Working Party it was possible to report back to the Standing Committee of the AUTP and draw on the experience of its members, who represent all the teaching departments of psychiatry in Britain. The results of these preliminary discussions will form the subject of the next section.

It was also evident that more detailed information would be needed about the special circumstances of individual teaching hospitals and that this would best be obtained by means of a questionnaire. The required information fell under three principal headings:

1. The nature of the resources that are available to each teaching department. In particular, we wished to know whether the teaching department was mainly based in a general hospital or in a mental hospital.

2. What are the resources of each teaching department of psychiatry in terms of psychiatric manpower at consultant level (including, of course, honorary consultants based in academic departments or employed by the Medical Research Council)?

3. What are the achievements of each teaching hospital department in terms of having developed appropriate clinical facilities, and established the important academic pursuits of undergraduate teaching, postgraduate teaching and research? As regards the level of clinical facilities it was thought particularly relevant to find out whether it had been possible for the teaching department to provide a full or only a partial District service. This clearly depended on whether there were good resources in terms of admission beds, outpatient facilities, day hospital places, psychogeriatric and community services.

The questionnaire was designed to elicit as much factual information as possible. It was also recognized, however, that with some of the questions it would be necessary to rely on the opinions of the psychiatrists in the individual departments. In order to obtain the most informed opinion, it was requested that the questionnaire be completed and signed by the Professor or Head of the Academic Department and, whenever possible, by the Chairman of the Division of Psychiatry in the teaching hospital.

The pattern of organization of the psychiatric teaching departments is so variable that it was necessary to provide operational definitions in order to elicit whether the main clinical resources were in a general hospital or a large psychiatric hospital of the traditional type.

All 12 teaching hospitals in London and 11 of the 13 in England and Wales returned the completed questionnaire. It became apparent that the different organization of psychiatric services in Northern Ireland meant that comparisons with other departments would not be possible. The Belfast department will therefore not be considered in this Report.

Special demands made on teaching hospital psychiatrists: Information based on discussions within the AUTP

1. Pattern of clinical services in the teaching hospital

The DHSS has recognized that a teaching hospital accepts referrals, particularly of patients presenting special problems, from outside its District. These referrals, which limit the time available for District patients, arise for a number of reasons:

(a) teaching hospital consultants may be particularly interested in special problems, have expertise in particular treatments or have access to

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specialized facilities. Often these referrals arise because the patient may not have responded to the sort of treatment available in the District where he lives and a second opinion or further investigation may have been thought desirable.

(b) Patients who are referred from the medical and surgical departments of the teaching hospital often live outside the District. Physicians and surgeons frequently encourage these more distant referrals of patients in order to obtain as wide a clinical experience as they can, their departments usually enjoying a relatively high level of staffing. These additional patients are often found to require psychiatric care as well. This kind of clinical service gives rise to heavy demands on the psychiatrist's time.

(c) Teaching hospital psychiatrists are usually involved in Staff and Student Health clinics. They may provide a psychiatric service limited to the hospital and medical school in which they work, or sometimes to the university as a whole. In both types of services, many of the patients live outside the District.

As well as taking note of the above clinical demands made on teaching hospital psychiatrists, we wished to ascertain the kind of District service provided by each teaching hospital. We sensed that there was much variation in the pattern of clinical practice from one teaching hospital to another—some offering a comprehensive service without any reliance on neighbouring hospitals (such as the local mental hospital), others passing on to them patients with chronic mental illnesses who required long-term rehabilitation or elderly patients with advanced dementing illnesses not amenable to medical treatment. Such teaching hospitals do not carry the full weight of a comprehensive psychiatric service.

The DHSS in its discussion paper also referred to honorary consultant sessions of academic psychiatrists who would contribute to the clinical services of the teaching hospital. The questionnaire elicited the information which allowed the inclusion of clinical sessions provided by these members of staff in the assessment.

2. *Standards of care in the teaching hospital*

The Working Party attaches great importance to the obligation on teaching hospital consultants to provide the highest possible standard of psychiatric care. Teaching standards in clinical psychiatry depend largely on the level of clinical care that can be provided for patients who are examined and clerked by the students or who are demonstrated to them. A high standard of care is also a prerequisite for research and for the introduction of new treatments. Every teaching hospital consultant has a special obligation to ensure that the service he and his colleagues provide is a model to students and others of what is desirable in psychiatric care and treatment and also that the case records are as full as possible.

3. *Academic contributions made by teaching hospital psychiatrists*

(*a*) *Undergraduate teaching:* The teaching of psychiatry to undergraduates is largely carried out by university and NHS staff at teaching hospitals. Much of the teaching of psychiatry to medical students is provided during their clinical clerkship which often extends over a full-time period of at least two months. This teaching is provided in a clinical setting which demands that the teacher demonstrates the nature of the clinical problems and their treatment during a ward round or outpatient clinic. Inevitably this slows down the rate at which clinical work can be done. The teaching also extends to other phases of the clinical curriculum, when interview teaching, 'liaison' teaching, revision courses and examination of students make heavy demands on the psychiatrist's time. The same is true of the teaching of applied psychology during the preclinical course on the behavioural sciences. Indeed it is probably the case that in most teaching hospitals where the department of psychiatry has endeavoured to influence the education of medical students the teaching commitments of the psychiatrist outweigh those of the physician or surgeon.

(*b*) *Postgraduate teaching:* The organization of regional postgraduate courses in psychiatry is often the responsibility of psychiatrists in the teaching hospital. In the rotational training fostered by the Royal College of Psychiatrists a special contribution is often expected from teaching hospital departments in terms of formal courses and supervision of research, as well as the clinical teaching which is shared with the 'non-teaching' hospitals. In particular the supervision of candidates for MD, M.Phil. or Ph.D. degrees with theses in psychiatry usually falls on the teaching hospital psychiatrist.

(*c*) *Research:* Teaching hospital consultants have an obligation to undertake research if only for the reason that some research is essential if teaching is to be based on attitudes of critical and questioning inquiry. That the output in research by teaching hospital consultants is relatively low is much to be regretted and is partly attributable to their excessive clinical and administrative loads.

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(*d*) *Additional contributions:* Teaching hospital consultants are particularly asked to act as examiners for their own and other medical schools and for their College, to lecture away from their hospital, to contribute to medical books or review articles, to join the editorial boards of psychiatric journals, to sit on appointments committees and to advise on other committees at Area and Regional level.

It is very difficult to express all these special demands on teaching hospital psychiatrists in terms of time no longer available for direct clinical work. Rather than attempt to do so it was decided to try to identify those teaching hospital departments of psychiatry that met all their clinical and academic responsibilities satisfactorily. It was reasoned that they would serve as models for other departments to follow, and that their staffing provisions would give a measure of the numbers of consultants needed for all departments to attain equally high standards.

Results of questionnaire inquiry from teaching hospital Departments of Psychiatry

A *Consultant manpower*

Most teaching departments make the widest possible use of consultants as teachers whether they work mainly in the teaching hospital or in the neighbouring mental hospital or clinics, but, because this inquiry is primarily concerned with the levels of clinical service, only consultants who work within the teaching hospital were included in the count. Sessions outside the teaching hospital were not included. Moreover, because we wished to equate consultant strength with the clinical service given to the District, the results shown will refer only to psychiatrists in general (adult) psychiatry, including the psychiatry of old age; consultants in the 'special interests' are not included. On the other hand, the important contributions of these specialist psychiatrists were taken into account when assessing the teaching department's potential strength in teaching and research. The Table (overleaf) shows the numbers of NHS and honorary consultants (mainly academic psychiatrists) and the total number of sessions which these two groups contributed to the clinical services in general (adult) psychiatry provided by each teaching hospital. It will be seen that there is much variation in the number of consultants and the sessions they work, ranging from only 4 sessions (from 2 consultants) in Leicester to 102 sessions (from 16 consultants) in Manchester.

A word of caution is needed to enable us to interpret these figures in the case of the larger connurbations such as Manchester and Leeds. In Manchester, the 102 sessions shown in the Table represent clinical sessions worked in three teaching hospitals: the University Hospital of South Manchester, Manchester Royal Infirmary (Gaskell House) and the Hope Hospital. Each of these hospitals teaches medical students from the University of Manchester, but they differ a great deal as regards their contributions to a psychiatric service. UHSM provides a comprehensive psychiatric service for a population of 211,000 in South Manchester, and relies very little or not at all on the local mental hospitals. On the other hand it is only possible to provide a limited clinical service from Gaskell House for Central Manchester in which it is situated, partly because there are only 18 consultant sessions available for a population of 200,000 but mainly because the admission facilities consist of only 19 beds and 10 day places. Similar restrictions apply to the Hope Hospital (36 psychiatric beds) which is nominally concerned with serving a population of 250,000 from North-West Manchester. Consequently, Prestwich Hospital (a large mental hospital) provides the main facilities for the admission of psychiatric patients from both these areas of Manchester, including short and medium stay admissions (less than one year). A similar situation exists in Leeds.

Both these examples illustrate how the nature of the psychiatric service may depend as much on the siting of admission beds and day hospitals (within the general hospital or the mental hospital), as on the number of consultant sessions. This fact must be taken into account when trying to equate the number of consultant sessions available and the nature of the psychiatric service provided from the teaching hospital.

The situation in London is similar, but the autonomy of the twelve medical schools (all within the University of London) makes it simpler to grasp the fact that a large connurbation may rely on several teaching hospitals with widely differing contributions to the local psychiatric services, according to the extent of their clinical facilities and their pool of psychiatric manpower.

B *Psychiatric facilities*

An assessment was made of the extent and quality of the facilities available for the provision of a psychiatric service from each teaching hospital. The facilities are graded on a five-point scale, with 1 indicating good resources in terms of beds, day places and other essential requirements and 5 at the other end of the scale indicating very poor resources inadequately situated. The ratings are shown in the Table, with brief notes indicating the

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Table

Results of Questionnaire Enquiry Form 23 Medical Schools in England and Wales (September 1976)

Medical School/ Teaching Hospital	(1) No. of consultants		(2) Consultant sessions	Clinical Resources		(4) Extent of district service	Undergraduate Teaching			Research	
	NHS	Academic		(3) Grade	Details		Size of academic year (No.)	Clerkship (weeks)	No. of consultant/ teachers	(5 Consultant participation	(6) Funds raised
Birmingham	3	3	48	3	Too few beds for teaching in the general hospital	3	160	10	26	2	2
Bristol	3	4	48†	2	Effort to break down barriers between teaching and non-teaching hospital. No distinct day hospital	2	120	8	10	3	1
Leeds											
1. General Inf.	0	3	21	4	Only a small inpatient unit	3					
2. St. James's	4	2	50	2	Good inpatient and day facilities	1	130	7	19	3	3
Leicester	0	2	4	5	Only psychogeriatric beds. Plans for new DGHs 'frozen'. Clinical teaching not begun	3	–	NA	2	3	3
Liverpool											
1. Royal Inf.	2	2	22	4	Teaching beds scattered between 4 units. New university hospital planned for 1978	3					
2. Sefton Gen. Hos.	3	1	37	2		1	150	8	23	3	3
3. Broadgreen Gen.	3	0	6	4		3					
Manchester											
1. Univ. Hosp. S. Manchester	7	6	72	1	Purpose-built large DGH unit with day places	1				1	1
2. Manchester R.I. (Gaskell House)			18	4	19-bed unit and 10 day places	3	260	7	21		
3. Hope House	3	0	12	4	36-bed unit only	3				1	3
Nottingham	2*	2	20†	4	Psychiatric unit planned in new DGH due to open in 1981. Academic department based in	2	96	8	8	2	2
Oxford	1	3	29†	3		3	75	8	9	1	1
Sheffield	1	3	29	4		3		12	11	1	1
Southampton	0	3	19†	2					21	2	2

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Cardiff	7	2	30	3	Limited inpatient and day facilities in new teaching hospital	2	150	3	10	1	1
Charing Cross	5	2	41	3	Psychiatric beds within DGH and associated unit	2		8	7	3	2
Guy's	3	1	26	2	Psychiatric beds within DGH and associated unit	3	100	10	10	1	2
King's College	4	2	45	4	Insufficient beds and out-patient accommodation in DGH	2	90	6	8	2	2
The London	3	2	40	2	Psychiatric beds within DGH and associated unit	1	120	8	6	1	2
The Middlesex	4	3	34	3	Only few beds in teaching hospital. More in associated unit	3	110	11	9	2	2
The Royal Free	5	5	48†	3	Good inpatient facilities in DGH but no day hospital	3	100	8	12	2	1
St. Bartholomew's	6	1	45	3	Psychiatric beds in branch hospital with deficient clinical facilities	1	140	12	13	1	2
St George's	8	4	51†	1	Good inpatient facilities within teaching hospital branches	3	72	12	16	1	1
St Mary's	2	2	30	2	Good inpatient and day facilities in branch of teaching hospital	2	100	8	7	1	2
St Thomas'	7	1	35	3	Psychiatric beds in teaching hospital branches	1	100	6	9	1	3
University College	4	0	25	4	Limited facilities in branch of teaching hospital	3	100	8	4	2	2
Westminster	5	1	29	2	Beds and day places only in scattered branches of teaching hospital	3	75	8	6	1	2

Notes

(1) The 'No. of Consultants' includes consultants in general psychiatry and in the psychiatry of old age.

(2) 'Consultant Sessions' are the total number of weekly sessions worked by NHS consultants and academic psychiatrists; a maximum of 7 weekly sessions are counted for each academic psychiatrist.

(3) 'Grading of Clinical Resources' is on a 5-point scale from 1 (near optimum) to 5 (primitive)—the main criterion is the level of clinical resources within the teaching hospital itself.

(4) 'Extent of District Service' is assessed on a 3-point scale: 1 comprehensive; 2 partial; 3 selective.

(5) 'Consultant Participation in Research' refers to the proportion of NHS consultants who are active in research: 1 high; 2 average; 3 low.

(6) Research funds raised over the course of 3 years graded on a 3-point scale: 1 >£50,000; 2 £10,000–£50,000; 3 <£10,000. (This figure was not clearly disclosed in some instances and had to be estimated.)

* In Nottingham the academic department is confined to the mental hospital; nevertheless the teachers there have been included.

† The academic consultants contribute several teaching service sessions to the mental hospital.

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assets or deficits in each teaching hospital. In making these grades it is assumed that it is highly desirable to have not only an adequate number of psychiatric beds and day places available for the District service, but also a large proportion of them within the teaching hospital itself. The reason for this is clearly that psychiatric patients nearly always prefer being treated in a general hospital rather than a mental hospital. Moreover, it is important for students to learn their psychiatry in the context of the teaching hospital itself so that they do not develop unfortunate attitudes towards psychiatric patients, attitudes which all too often originate from seeing these patients relegated to a distant hospital, away from the mainstream of medicine. In the grading of the psychiatric services provided by a teaching hospital, it is considered an asset to have part of an academic unit within a mental hospital, so long as the teaching hospital itself is well provided with consultant psychiatrists and psychiatric facilities. Similarly, it is thought advantageous for students to spend part of their clerkship in a nearby mental hospital, but the greater part should be spent within the teaching hospital. The findings are summarized in the Table, and it must be conceded that the assessments can only be judged to be very approximate. In the case of some centres, good teaching and clinical facilities have been developed in units separated from the general teaching hospital (e.g. Oxford, the Middlesex). In their case, the line of division that we have drawn may appear somewhat arbitrary and the gradings given in the Table may not do justice to their high level of teaching and clinical practice.

It will be seen that very few teaching hospitals are well endowed as regards their psychiatric resources. Very few have sufficient beds or day places within the teaching hospital, and most rely on a more or less distant mental hospital. Examples may be useful. Cardiff has a small in-patient (48 beds) and day unit (12 places) within the recently-built University Hospital of Wales which houses the academic department of psychiatry. Whitchurch Hospital is the mental hospital for Cardiff and has the advantage of being of reasonably small size and within the city; it also houses part of the academic department of psychiatry. The University Hospital of South Manchester contains a relatively large recently-built psychiatric inpatient unit with day places in which is accommodated the academic department of psychiatry. This is in contrast with the depleted psychiatric facilities of the Manchester Royal Infirmary and the Hope Hospital. In London, St George's has well established resources (43 beds) in the Atkinson Morley Hospital (Wimbledon), outpatient facilities in a newly-built general hospital (Tooting) and a professorial unit in the nearby mental hospital (Springfield). The Royal Free Hospital has a new medium-sized psychiatric in-patient unit within the new teaching hospital and a small unit in the mental hospital (Friern), but is singularly bereft of any day places. University College Hospital has no psychiatric beds within the teaching hospital building proper and is highly dependent on Friern Hospital. Worst of all, UCH is still without a professorial department of psychiatry, a deficiency shared only with St Thomas' and Westminster Hospitals. Finally, Leicester must be regarded as the most barren psychiatric desert in the country, the academic department having no access to beds in general psychiatry (psychogeriatrics only) and no opportunity to provide a liaison service with the medical and surgical areas of the general hospital. Plans for district general hospitals with psychiatric units in Leicester are 'frozen'.

C *Assessment of the achievements of the Psychiatric Departments*

1. *Clinical Services*

It is clearly difficult to assess the quality of the psychiatric service provided by a teaching hospital, but we shall use as our yardstick the degree to which a comprehensive District service is provided, based on the teaching hospital itself and depending as little as possible on neighbouring hospitals such as the mental hospital. Again, it is hard to do more than devise a rough-and-ready three-point scale:

(1) indicates that the teaching hospital accepts responsibility for all psychiatric admissions from the District, including patients with chronic illnesses and elderly patients with poor prognoses.

(2) indicates that the teaching hospital will probably accept most short and medium-stay admissions but will depend on the mental hospital for the admission of patients who relapse frequently, or are elderly or chronically ill.

(3) means that the teaching hospital provides a highly selective service, screening carefully the admissions and depending very largely on the mental hospital.

The best example of a comprehensive District service being provided by a teaching hospital is that of the University Hospital of South Manchester. Even here, however, the senior staff concede that there are considerable shortcomings in the local authority services for the rehabilitation of patients with chronic illnesses. The London Hospital and St Bartholomew's also endeavour to provide a full District service. The Bart's psychiatric unit is not

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within the main teaching hospital but in Hackney Hospital, where the senior psychiatric staff have endeavoured to provide the fullest possible clinical service in spite of seriously deficient resources. In most other teaching hospitals, both in London and in the provinces, only a partial or a selective District service is provided. In Nottingham the situation is a special one: the academic department will remain entirely housed in the mental hospital (Mapperley) until 1981 when a new University teaching hospital will be completed. Accordingly the matter of a District service based on a teaching hospital will not arise until then.

2. *Teaching*

(*a*) *Postgraduate teaching:* The questionnaire was not primarily designed to elicit information about postgraduate teaching, but much is already known about the contributions of teaching hospitals to the rotational training programmes. This information has been made available as a result of the Royal College's inspections of training programmes at senior house officer and registrar level, and from the work of the Joint Committee on Higher Psychiatric Training (at senior registrar level). In general, teaching hospitals are asked to provide valued places in the rotation schemes. Their participation ensures that the standard of training is raised and opportunities are given to the trainees for gaining experience in teaching medical students, and possibly in tackling a research project.

As already indicated, the supervision required from the teaching hospital consultants can be onerous, but there are substantial benefits to the training programme as a whole, and the level of recruitment of new trainees tends to be raised. Most of the teaching hospitals surveyed endeavoured to make some contribution to these postgraduate programmes, and in some instances it was a considerable one comparing favourably with postgraduate programmes in medicine and surgery.

(*b*) *Undergraduate teaching:* It is clear that the teaching of medical students is one of the highest priorities, if not the highest, for the psychiatric departments of the teaching hospitals. The information given in the Table falls under three headings:

- (i) the number of medical students in an academic year
- (ii) the length of the clerkship in psychiatry (expressed in full-time equivalents)
- (iii) the numbers of consultants involved in teaching.

The size of the student year ranges from 70 to 140 in the London medical schools (100 is the most frequent figure). In other medical schools the student year tends to be somewhat larger (usually ranging from 75 to 160 with a record 260 set by Manchester).

The usual length of the clerkship in psychiatry is 8 full weeks, with Cardiff, King's College Hospital and St Thomas' falling below this figure but several medical schools providing up to 12 weeks.

The number of consultants and honorary consultants contributing to the teaching varies a great deal. A large number often represents a substantial participation of consultants in outlying mental hospitals where groups of medical students are accepted for at least part of their clerkship.

Taken as a whole, the teaching of psychiatry to medical students in England and Wales has advanced considerably since 1966–67 when Carstairs *et al.* last surveyed the subject.

3. *Research*

There was enormous variation between the various departments of psychiatry both in consultant participation and in ability to attract research funds. A few departments (Bristol, Manchester, Oxford, the Royal Free, St George's and Sheffield*) had each succeeded in raising well over £100,000 for research over the course of the three years covered by the survey. On the other hand, there was confirmation of the general impression that most departments of psychiatry have only a small commitment to research, and that the majority of consultant psychiatrists in teaching hospitals devote little time to research.

Conclusions

The psychiatric profession has reason to thank the Department of Health and Social Security for raising the question of the special claim of teaching hospitals for an increment in consultant staff. We agree with the view expressed by the DHSS in their discussion paper that, whereas there are reasons for a higher consultant to population ratio for teaching Districts, it is extremely difficult to express this in terms of a figure for a national increment. We believe, however, that a problem exists, for the present survey has revealed serious deficiencies in the resources available within teaching hospitals, which militate against the provision of an adequate psychiatric service and the establishment

* The Sheffield department had an MRC unit at the time of the survey (September 1976) but soon after then the MRC decided to have it totally dismantled.

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of psychiatry as an academic discipline. The survey has also disclosed a few alarming examples of teaching hospitals where conditions and staffing levels are rudimentary in the extreme.

It is clear that most psychiatric departments have accorded a high priority to the teaching of psychiatry to medical students. Of the other academic pursuits, postgraduate teaching in psychiatry has made considerable strides forward in recent years. Regrettably, psychiatric research is still accorded a low level of priority. The usual reason given is the pressure of clinical and administrative work, but the profession should not accept this excuse too readily and should encourage its members to become more active in research.

It is the contribution of the teaching departments to the clinical psychiatric services that is the main concern of this paper. Teachers and consultants in teaching hospitals have hitherto taken the view that their limited clinical resources require that psychiatric treatment be given to highly selected patients. The arguments in favour of this approach are cogent. Such a selective service is the most economical way of introducing medical students to psychiatry of the more hopeful and appealing variety. This kind of teaching of psychiatry would be most relevant to the needs of future general practitioners, whereas the problems of the more intractable mental illnesses might remain the province of the specialists in psychiatry. In any case this approach by the teaching departments of psychiatry is often enforced because of inadequate staffing levels and a shortage of admission beds, day places and facilities for patient rehabilitation, all of which are inimical to the provision of a comprehensive District service.

Yet opinion among teachers of psychiatry is changing in this respect. The view is gaining ground that teaching hospital departments should endeavour to provide a comprehensive District service in order to demonstrate to students how to tackle the more resistant problems of psychiatry, and how to develop and apply social methods of treatment in accordance with the principles of modern psychiatric practice. The establishment of such a service also opens the doors to a more accurate appraisal of methods of psychiatric treatment and provides additional opportunities for clinical and epidemiological research.

We are therefore tempted to pursue further the question put to us by the DHSS: what steps should be taken in order to allow those teaching hospital departments that favour having a full District service to implement one without damaging the essential academic endeavours of teaching and research? At this stage it is worth mentioning that at least one teaching department (Bristol) has gone some way towards fulfilling this aim by breaking down demarcations between teaching and 'non-teaching' services. Indeed some blurring of roles is present in most teaching Districts. The fact remains that there are some differences, however indistinct, between teaching and 'non-teaching' hospitals, and that these are important to patients as well as to medical students.

The original aim of the present survey was to see what level of consultant staffing was compatible with a full District service based on the teaching hospital. It was found, for example, that a comprehensive District service for a population of 210,000 was provided by the University Hospital of South Manchester with a staff of 11 consultants pooling a total of 72 clinical sessions. Five of these consultants are academic psychiatrists heavily committed to teaching, administration and research; it is assumed that the NHS consultants in this hospital must also make similar but possibly less onerous contributions to academic work. It would therefore seem more realistic to equate the population served with the number of consultants rather than the number of sessions, and this leads us to an approximate measure of one full-time consultant per population of 20,000. There are two important provisos well illustrated by the special case of Manchester. The senior psychiatrists of that University department admit themselves that the rehabilitation services for the chronically ill patients fall short of a satisfactory level. On the other hand the University Hospital of South Manchester is unusual in that its psychiatric units were built recently and on a scale that is unique in the teaching hospitals of England and Wales.

Thus we arrive at what is perhaps the most important finding of this survey. The most significant limiting factor that prevents a teaching hospital from providing a full District psychiatric service often lies in a shortage of admission beds, day places, occupational therapy and other therapeutic resources. Staffing shortages are also important, but to solve them without improving the clinical facilities would do little to ensure the provision of fuller psychiatric services by the teaching hospitals.

In conclusion, with the best will in the world teaching hospitals cannot provide a comprehensive District psychiatric service without two basic conditions being met—much improved clinical resources within the teaching hospital itself, and a consultant to population ratio of at least 1 to 20,000.*

* This figure refers to the availability of consultants in adult psychiatry and the psychiatry of old age, in line with the definition used in this survey. Specialist consultants

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(child psychiatry, mental handicap, forensic psychiatry, psychotherapy and drug dependence) are not included. Their contributions are crucial but they are not usually measured in terms of a district service.

This ratio should be raised in the case of teaching hospitals that provide psychiatric treatment for substantial numbers of patients referred from outside the District. If the conclusions of this survey are faulty, it is almost certainly in the direction of too modest an estimate of the staffing needs. The reader is reminded of the Report of the Committee appointed by the Secretary of State for Scotland (the Wright Report) in which it was recommended that professorial teaching units of psychiatry should have a level of medical staffing (senior and junior) three times that of 'non-teaching' units. Our recommendation is that the level of staffing should be twice as high in the teaching hospital. The Wright Report was published in 1964, admittedly in the days of greater affluence within the National Health Service. There is reason to believe that its constructive recommendations helped teaching units in Scotland to become much more firmly established than south of the border.

Psychiatrists working in teaching departments in England and Wales might consider setting up comprehensive District services if they are fortunate enough to have achieved the basic levels of clinical resources and consultant staffing put forward in this paper. It would seem prudent, however, to tailor the District served to a size that still permits the demonstration of high quality clinical practice to medical students. It is also essential for substantial help to be given to the impoverished psychiatric teaching unit in Leicester: clinical resources and psychiatric staff are urgently needed if teaching obligations to the first intake of clinical students is to be met. Strong encouragement should also be given to the University Grants Committee and the University of London to establish professorial departments in the three medical schools that still have no chair of psychiatry—University College Hospital, Westminster Hospital and St Thomas'.

Acknowledgements

We are extremely grateful to all our colleagues who have painstakingly completed yet another tedious questionnaire.

References

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COLLEGE ANNOUNCEMENTS

PSYCHOTHERAPY SECTION

An Open Meeting will be held on Wednesday, 13 December, at the Tavistock Centre, Belsize Lane, London, N.W.3, at 8.15 p.m., when Dr J. Pedder will speak on 'Transference: its place in play and theatre'.

COLLEGE PLAQUES AND CHRISTMAS CARDS

A plaque measuring 7″×6″ approximately and showing the College Coat of Arms in four colours raised on a wooden shield of light oak, is now available. The price is £5.50 if bought at the College; £6.00 by post for U.K. and £6.50 for overseas surface mail, including postage and packing.

A College Christmas Card is also available. The Coat of Arms is die-stamped on the front in four colours, on a card measuring 6″×4½″. Price, including envelopes, 6 for £1.00, 12 for £2.00, including postage, for U.K. For overseas Air Mail postage add 75p for 6, £1.45 for 12.

ASSESSMENT OF POSTGRADUATE TRAINING IN PSYCHIATRY

A one-day Conference on this topic, organized by the Clinical Tutors' Sub-Committee of the College, will be held on Monday, 5 February 1979, at the Scientific Societies Lecture Theatre, Fortress House, 23 Savile Row, London W1. The President, Professor D. A. Pond, will be in the Chair, and speakers will include Professor H. J. Eysenck, Dr J. L. T. Birley, Dr J. F. Stokes and Professor H. J. Walton. Application forms and further details can be obtained from Miss Jane Boyce at the College.

Ian G. Bronks
Secretary, Clinical Tutors' Sub-Committee

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