Improving working lives

Rafey Faruqui is quite right that appropriate workloads and good working conditions are essential ingredients for maintaining good recruitment and retention of consultant psychiatrists (Psychiatric Bulletin, November 2003 correspondence, 27, 437). The question that my editorial, ‘Locums — and the light at the end of the tunnel’, tried to address is: how can those things be achieved when there is such an imbalance in supply and demand, causing work overload for many psychiatrists (Psychiatric Bulletin, August 2003, 27, 281–282)? Dr Faruqui agrees that reliance on a locum workforce is ‘pathological’, and no kind of a solution.

In that respect, the letter by Skudder, of Psyche UK Ltd (Psychiatric Bulletin, November 2003 correspondence, 27, 437), which grossly misrepresents what I wrote, invites the question of whether a declaration of interest of a locum agency should have been made.

The recent expansion of medical schools will not be felt for more than a decade at consultant level. Meanwhile, demands on psychiatrists working in traditional ways will very likely continue to grow. It is hopeful, therefore, to see so many items appearing in the Bulletin about how roles and working practices of psychiatrists can change to reduce their case-loads and improve working conditions.

The College is addressing this complex issue, and consulting its members on the options through the College website (www.rcpsych.ac.uk) and the Bulletin. It is an issue of crucial importance to the future of the profession and mental health services. Therefore, the views of specialist registrars will be particularly important.

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In defence of locum consultant psychiatrists

Peter Kennedy (Psychiatric Bulletin, August 2003, 27, 281–282) has concerns about the quality and cost of locum consultants. Quality would be best assessed by the Royal College of Psychiatrists, as with CCSTs, perhaps by a retired consultant. The lack of a national database represents a failure of management at the Department of Health, as does its failure to establish a register of those other expensive wanderers, patients with Munchausen syndrome.

Do I detect a note of envy at the £180k that locums receive? Fewer would be needed if three sessions extra were paid to over-worked general consultants. My impression is that home graduates tend to do less demanding jobs in liaison psychiatry, cognitive—behavioural therapy, and eating disorders, leaving the ‘dirty jobs’ to those qualified abroad. The pits of medicine, namely psychiatry, geriatrics and inner-city GP posts, have traditionally been filled by graduates of South Asia (Passage from India, Guardian, 27 August 2003). Recruitment remains difficult, due to under-financing and bed closures, against a doubling of the incidence of schizophrenia in London (Boydell et al, 2003). If a similar increase were to be found in epilepsy or diabetes, then extra resources, both in hospital and community, would be made available.

How much are consultants worth? The answer is £450–500k, which is the payment at direct treatment centres for surgical waiting lists.

Declaration of interest

I may do some locum work, at the rate the market will bear.

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The columns

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Psychotherapy training in the Northwest — a survey

Training in psychotherapy is now recognised as a significant component in the overall training of psychiatrists. The College has delineated psychotherapy training requirements for trainees in different stages of their training, but these are not yet a precondition to sitting the MRCPsych examination (Bateman & Holmes, 2001; Royal College of Psychiatrists, 2001). We conducted a survey of trainee experiences in psychotherapy and existing training resources in Northwest England. Questionnaires were sent to college tutors and psychiatry SHOs in Manchester deanery (response rate 40–60%). Information from trainees suggests that a third of year 2/3/4 trainees had not undertaken a single psychotherapy case.