The Recruitment Problem in Psychiatry:
A Critical Commentary

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The continuing shortfall in recruitment to Psychiatry is examined with suggestions for affirmative action. Recruitment may improve in the near future because of the high demand for psychiatrists, the incentives offered, greater competition for other specialties and a pool of international graduates willing to work in Psychiatry. There remains the long term challenge of how to inspire positive vocational interest given the persisting stigma of mental illness, a legacy of negative attitudes towards Psychiatry, stressful aspects of the work and increasing encroachment on Psychiatry's jurisdiction in the treatment of mental illness. Accepting the importance of giving students and graduates a good exposure to Psychiatry it is also important to make a critical appraisal of what they see. Realistic disincentives may be overlooked against a background of stigma and prejudice and arguably insufficient attention has been given to addressing realistic disincentives. It is suggested that the emphasis on reductionist explanations in Psychiatry today will not benefit recruitment or Psychiatry. Open acknowledgement and discussion of problematical theoretical and practical issues might lead to greater vocational interest and attract graduates interested in advancing and not merely practicing the Psychiatry.

Introduction

Recruitment to Psychiatry in the USA and UK has not recovered from the downturn that became evident in the 1970s (Brockington & Mumford, 2002). In 2010, statements like the following were appearing routinely in publications related to selection in Psychiatry:

> The recruitment crisis...[which is leading to]...unacceptable variation in quality amongst trainees and consultants...is the biggest challenge psychiatry faces (R. Howard, Dean, Royal College of Psychiatrists, England, April, 2010).

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> Psychiatry is a recruiting, not a selecting specialty. (M. Maier, Head of the London Specialty School of Psychiatry, April, 2010).

Suggested solutions and promotional programs have not been effective overall and uncertainty remains about future developments. Psychiatry is a 'greying' specialty and it has been questioned whether psychiatrists are an endangered species (Katschnig, 2010). Possibly the continuing slump in recruitment is merely a longish downswing in periodic variation (Brockington & Mumford, 2002; Sierles & Taylor, 1995) and perhaps an upswing is imminent. If there are some grounds for optimism in this regard (Sierles et al., 2003) there is no room for complacency because the shortfall in recruitment today does not reflect the full extent of disinterest. Established training positions are being filled increasingly by international rather than local medical graduates. In the UK for example, the ratio of international to local graduates entering the Psychiatry training programme in 2009 was approximately 6:1 – a much greater ratio than in other specialties (Fazel & Ebmeier, 2009). An increase in undergraduate numbers might also obscure positive interest. With greater competition for preferred specialties, Psychiatry might be seen as an acceptable alternative since it does offer attractive incentives: vacancies in increasingly well paid consultant positions in the public sector, no shortage of work in the private sector, openings in academic positions, opportunities for combined public/private practice and sub-specialization, 'family friendly' work hours and increasingly sought after 'life-work balance'. There is also the intellectual challenge of mental illness for those interested in research. With all these incentives, one might expect graduates to queue for the diverse career prospects in Psychiatry. The reality is a relative lack of interest and whilst demand, incentives and more students might boost recruitment, filling vacancies does not guarantee vocational interest or the advancement of Psychiatry.

Recruitment problems in Medicine are not confined to Psychiatry but the concern in Psychiatry is that the disinterest is an expression of negative perceptions and attitudes. Long recognized 'negatives' include the stigma of mental illness, difficulties of dealing with the mentally ill, relatively low income, lack of respect from medical peers, weak scientific foundations, ineffective treatment and uninspiring role

models (Brown, Addie, & Eagles, 2007; Malhi et al., 2002; Feifel, Yu Moutier, & Swerdlow, 1999; Furnham, 1986). Income has improved in many places but other negatives have not changed significantly. The question for Psychiatry is to what extent these negatives are justified or prejudicial. It is often suggested that giving students a better exposure to Psychiatry would lessen negative perceptions. However different authors have found that the benefits of a good exposure are short lived with no increase in career interest or fundamental changes in attitude (Bobo, Nevin, Greene, & Lacy, 2009; Dixon, Roberts, Lawrie, Jones, & Humphreys, 2008; Fischel, Manna, Krivoy, Lewis, & Weizman, 2008; Galka et al., 2005; Reddy et al., 2005; Sierles & Taylor, 1995; Creed & Goldberg, 1987). Even when students indicate a positive attitude towards Psychiatry, there is no corresponding increase in vocational interest (Ndetei et al., 2008; Balon et al., 1999). Together, these findings suggest that disinterest in Psychiatry is less a case of poor marketing and more a problem of marketing what continues to be perceived as an unattractive 'product'. If this is the case then 'more of the same' in unlikely to improve recruitment.

Trainee retention problems raise higher order concerns insofar as they reflect deficiencies in training programs and/or disenchantment with working in Psychiatry. Different authors have commented on the high attrition rate of trainees in the UK (Clarke-Smith & Tranter, 2002; Cox, Ryan, & Hanna, 2000) and the withdrawal from a pursuit of Psychiatry by doctors with an initial interest (Pidd, 2003). Trainees who passed stage I of the MRCPsych examination but did not progress to stage II complained of poor supervision and a lack of support in exam preparation (Cox, et al., 2000). Whilst these complaints reflect badly on a specialty that has a recruitment problem and is supposedly attentive to interpersonal relationships, they are potentially remediable. It may be more difficult to address the complaints of Senior House Officers in the UK who abandon their initial interest in Psychiatry for reasons that include the depressing work conditions, the high numbers of challenging patients, inadequate staffing and observation of low morale in their consultants and in other staff (Pidd, 2003). These complaints are not unique to UK Senior House Officers and if graduates with an interest in Psychiatry are left to discover these realities, their disenchantment should not be surprising.

Graduate career choice in medicine is a complex and often changing decision that might involve considerations such as scientific and humanitarian interest, financial reward, status, precedent, personal and family reasons, perceived opportunities, influence of role models, educational and clerkship experiences. The reasons students and graduates have usually given for disinterest in Psychiatry do not explain the variation in recruitment over the years. For example Psychiatry has always been criticized for its weak scientific foundations but in the USA recruitment peaked between 1945-69 (Brockington & Mumford, 2002) when 'unscientific' Psychoanalysis exerted a dominant influence whereas it declined with the demise of psychoanalysis and the rise of supposedly more scientific 'biological' Psychiatry. There was no corresponding change in negative perception: the stigma of mental illness did not lessen and psychiatrists did not enjoy any better income, status or peer respect. Whether it was the intellectual attraction of Psychoanalysis or a combination of factors, the lesson from history is that recruitment may vary widely despite persistence of the same 'negatives' reported in different surveys for more than half a century. It is also relevant to note that despite the overall recruitment downturn in the last three decades, there is evidence of considerable variation in student interest. For example a study in 2005 (Abramowitz & Bentov-Gofrit, 2005) found that 32.8% of preclinical Israeli medical students considered a residency in Psychiatry, compared to 7.7% in the USA and 15.9% in Australia. Such variation may be due to differences in teaching or 'exposure' but social and cultural factors may also contribute. Understanding the reasons for such variation might help to delineate more effective strategies for improving recruitment and possibly difference strategies are required in different places.

Little attention has been given to potential recruitment problems created by Psychiatry's weakening jurisdiction in the treatment of mental illness. Craddock believes that a downgrading of the medical treatment of mental illness has left British psychiatry facing an 'identity crisis' and suggest that the changes leading to this crisis '...have been driven in part by government but there has been both active collusion and passive acquiescence by psychiatrists themselves' (Craddock et al., 2008). American psychiatrists have been publicly accused of confining their treatment to 'prescribing' (Harris, 2011) and it may not be long before

American Psychiatry has to give more serious attention to reviewing its professional boundaries and 'identity'. Students and graduates are unlikely to be attracted to a specialty that is undergoing an 'identity crisis', especially since concern with its 'identity' has featured far more prominently in the history of Psychiatry than in other specialties (Reynolds, Lewis, Detre, Schatzberg, & Kupfer, 2009; Cooper, 2003; Hobson & Leonard, 2001; Guze, 1989; Anonymous, 1985).

Failure to discuss and clarify theoretical differences between psychiatrists might also have a negative effect on recruitment. Psychiatrists generally endorse a 'bio-psycho-social' approach to the understanding and treatment of mental illness but will often convey, or admit to, a preferred 'orientation' that might, as suggested by Pidd, have contributed to the 'identity crisis' in British Psychiatry. Psychiatrists with a strong orientation towards 'social psychiatry' might give students a significantly different perspective than those with a strong 'biological' orientation and it may be difficult for students to perceive a cohesive unity amidst the diversity of what they hear from different quarters. More than a few have been heard to complain that 'psychiatrists can't seem to agree amongst themselves'. There is disagreement in every specialty and given the limited understanding of mental illness it would not be surprising if there were more disagreement in Psychiatry. The problem in mainstream Psychiatry today is that there is little tolerance of, or opportunity for, open debate on controversial theoretical issues. The situation is a little like that of a totalitarian regime in which citizens must accept the 'party line' and the party line in Psychiatry today is biological reductionism.

What follows is a more detailed discussion of issues touched on briefly above.

Mental Illness is *Not* Like Any Other Illness

The history of mental illness is in large part a tale of stigma and it is understandable that negative perceptions have extended to professionals working in the field. The stigma has not lessened (Thornicroft, Brohan, Rose, Sartorius, & Leese, 2009) and remains a factor contributing to career disinterest in Psychiatry today (Dixon, et al., 2008). Stigma is not confined to mental illness but whereas the reality of stigmatized

physical disease (e.g. sexually transmitted disease) is not in question, the stigma of mental illness derives in part from its uncertain nature and perceived difference to physical illness – which is why today's attempts to remove stigma insist that 'mental illness is like any other illness'. Attempts to remove stigma are laudable but mental illness is *not* like any other illness (Albee & Joffe, 2004). There are similarities but there are also important differences. One major difference is the extent to which mental illness changes a person. The personality changes with serious mental illness (SMI) amount to a qualitative difference in comparison with 'any other illness' (except for certain 'organic' brain disorders). Not infrequently a person afflicted with SMI becomes unpredictable, difficult to relate to and dangerous to him/herself. Students and physicians experience difficulties in dealing with mental illness and the mentally ill (Dixon, et al., 2008; Mukherjee, Fialho, Wijetunge, Checinski, & Surgenor, 2002) and it would be unreasonable to suggest that the difficulties experienced reflect only prejudice. Individuals with a mental illness and/or certain types of personality disorder can be difficult to deal with even for mental health professionals (Schulze, 2007; Deans & Meocevic, 2006; Lauber, Nordt, Braunschweig, & Rosser, 2006; Sriram & Jabbarpour, 2005). A second major difference is that SMI frequently forces mental health professionals into a medico-legally binding policing role to ensure the person does not self-harm, commit suicide, harm others and complies with treatment. Together the change in personality and the coercion/policing in treatment make mental illness significantly different from physical illness. Medical students and graduates cannot fail to notice these differences. One of the positive aspects of Psychiatry may be the closeness of the doctor-patient relationship but this does not apply to the coercive aspects. Nor does it apply to the management of 'revolving door' self-harming personality disorders, substance abusers and violent individuals. Psychiatry more than other areas of Medicine has become increasingly responsible for managing social and behavioural problems that are not symptoms of a brain disorder/disease. What today's medical students and interns see of psychiatric presentations to Emergency Departments and other places of practice may be a strong disincentive for a career in Psychiatry. It is important to acknowledge the unrewarding and stressful aspects of psychiatric practice today and put them into proper perspective when

supervising students and interns (Cutler, Alspector, Harding, Wright, & Graham, 2006). Errors of omission in this regard may leave students with a skewed perspective and heighten negative attitudes towards mental illness and Psychiatry. Endorsement of propaganda-like insistence that 'mental illness is like any other illness' might be perceived as intellectually misguided or dishonest and add to negative perceptions. It might be better to acknowledge that mental illness is significantly different to physical illness and emphasize the interesting and intellectually challenging differences.

Recruitment and Approaches to the Understanding of Mental Illness

Psychiatry is a history of changing ideas about the nature and cause of mental illness and 'biological' theories are dominant today. With the rapid decline of Psychoanalysis in the 1970's there followed by a strong swing to biological reductionism and the dominant position in mainstream Psychiatry today is that mental illness is primarily a genetically predisposed brain abnormality. All textbooks continue to endorse a 'bio-psycho-social' approach to treatment but favour biological explanations for the aetiology and understanding of mental illness. However all explanations of mental illness remain contestable theories and premature closure on biological theories might alienate potential recruits who see the relevance of psychosocial factors not only in treatment but also in the aetiology of mental illness. Psychiatry becoming more 'biological oriented' and 'medically conventional' were identified reasons for a decline in recruitment (Sierles & Taylor, 1995). Individuals interested in 'nurture' contributions to mental illness might not be attracted to a Psychiatry that is antagonistic to psychosocial theories of causation and a good example of such antagonism is revealed in comments made by Harold S. Koplewicz, a leading child and adolescent psychiatrist in the USA and keynote speaker at the 1999 White House conference on mental health:

"It's hard to believe that until 20 years ago we still believed that inadequate parenting and bad childhood traumas were the cause of psychiatric illness in children. And in fact, even though we know better today, that antiquated way of thinking is still out there, so that people

who wouldn't dream of blaming parents for other types of disease, like their child's diabetes or asthma, still embrace the notion that somehow absent fathers, working mothers, over-permissive parents are the cause of psychiatric illness in children." (Koplewicz, 1999)

The reality is 'we *don't* know better today'. There is evidence that 'bad parenting' (including sexual and other forms of abuse) contributes to personality problems and mental illness (Harkness & Lumley, 2008; Read, van Os, Morrison, & Ross, 2005) and there is no justification for Koplewicz' position statement that reads like a warning to anyone who does not share his belief. There is no satisfactory proof for any theory as yet and under the circumstances Psychiatry would do better to promote a culture of cooperative pluralism (which does not mean tolerable 'eclecticism') and acknowledge that it does not as yet have a satisfactory explanation for the nature and cause of SMI (McLaren, 2007). It has been suggested more than once that Psychiatry should confine attention to SMI like schizophrenia and bi-polar affective disorder and leave the rest to psychologists and other mental health professionals. Unfortunately it is difficult to define the boundary between minor and major disorders and confining attention to SMI might further remove Psychiatry from giving due consideration to psychosocial factors in the aetiology of mental illness. The idea that a traumatic family life or otherwise adverse development experiences might cause mental illness has been practically abandoned in mainstream Psychiatry today. Moreover any proposal to investigate such questions is likely to be looked upon askance or actively discouraged. The problem with the current emphasis on reductionist explanations is that it can lead to clinical and intellectual myopia, does not accord well with the reality of clinical presentations, contributes to an abrogation of responsibility in patients, favours reliance on physical treatment and leaves awkward questions of credibility. Students and graduates potentially interested in Psychiatry might find it difficult to reconcile the emphasis given to the biology of mental illness with what they see in clinical practice and the questionable 'disorders' classified in the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Scull has suggested that DSM was the 'primary weapon' in the revolt against psychoanalysis and described it as 'an anti-intellectual system...(that)...proliferates pages and disorders, like

the Yellow Pages on steroids' (Scull, 2010). This may sound indulgently provocative but many DSM disorders are not usefully understood as a primary or even secondary 'brain disorder/disease' and the sheer proliferation of disorders over the years must cast serious doubt on the primacy of any assumed biological underpinnings. There is a danger that potential recruits will lose interest if they come to regard Psychiatry as medicalizing problems of life.

Given that SMI is associated with an abnormality in brain structure/function, it is not known to what extent psychosocial factors might have contributed to cause it. Questions of psychosocial causation are ultimately 'psychosomatic' questions about the extent to which, and the mechanisms by which, psychological and social factors can contribute to cause mental (and physical) illness. Psychiatry's difficulty with the idea of psychosomatic causation and disorder is reflected in the terminological and conceptual shifts in successive DSM manuals. If there is some justification for these shifts, there is no justification for de-emphasizing the importance of psychosomatic research. It is an area that may be especially appealing to individuals interested in Psychiatry in that it involves questions of 'mind-brain' or 'mind-body' relationships and the impact of the social environment on mental (and physical) health – difficult and intellectually challenging questions that are ignored in today's emphasis on reductionist biological research. Arguably questions of psychosomatic relationships constitute the defining domain of inquiry in Psychiatry and more active promotion of psychosomatic research might attract more interest in Psychiatry.

Nobel Laureate Eric Kandel has warned Psychiatry repeatedly that it runs the risk of being sidelined as a medical specialty (and by graduates) unless it establishes closer research links with neuroscience (Kandel, 2005). He believes that Psychiatry has failed to capitalize on the 'golden age of neuroscience' and that active involvement in neuroscience research would bring back excitement and recruits to the field. Studies have found that students regard psychiatry as 'unscientific' and 'boring' (Rajagopal, Rehill, & Godfrey, 2004) and students with these perceptions might be more interested in a strongly neuroscientific Psychiatry. Recognizing the relevance of neuroscience does not lessen the need for pluralistic understanding and it is doubtful

that greater emphasis on neuroscience research would boost recruitment as suggested by Kandel. Psychiatry is a clinical specialty and there is already strong support for neuroscience today even if most clinicians are not actively involved in neuroscience research. Individuals interested in neuroscience might not want to train in Psychiatry and most psychiatrists only want to apply clinically relevant knowledge gained from neuroscience. Focus group discussions between students holding different beliefs about the nature and cause of mental illness may be an effective strategy for lessening stigmatizing tendencies and raising awareness of the complex issues involved in mental illness. It may be a mistake simply to teach the Psychiatry of the day without engaging students in the problematical aspects of mental illness that have led to fractious debate and theoretical factionalism throughout the history of Psychiatry. Teaching in Psychiatry should stimulate a desire not only to practice Psychiatry but also to further understanding. The inclusion of philosophical discussions about the problem of mental illness in clinical teaching may change negative perceptions into fascination and evoke a desire to take up the challenge of advancing understanding.

Student/Peer Perceptions of Psychiatry and Their Effect on Recruitment

Psychiatry has always had an 'image problem' in the eyes of medical students and medical peers. A study in 1986 involving 449 medical students in London (Furnham, 1986) found that psychiatry was considered the most ineffective unscientific and conceptually the weakest specialty. A study in 1999 found that more than one-quarter of new medical students had already definitely ruled out a career in psychiatry (Feifel, et al., 1999). An Australian survey of 655 first year medical students found that students viewed psychiatry as distinctly less attractive than other career options and it was concluded that psychiatry has a 'widespread image problem' that is a reflection of community perceptions (Malhi, et al., 2002).

Expressions of disrespect towards Psychiatry by medical peers are not uncommon and contribute significantly to negative attitudes towards Psychiatry in medical students (Brown, et al., 2007; Balon, et al.,

1999). Psychiatry has always been the 'poor cousin' specialty within Medicine and this is largely because it is perceived as resting on weak scientific foundations. There is some justification for the perception. Psychiatry has not progressed beyond a descriptive stage in diagnosis and classification and there is little evidence of cumulative progress in scientific understanding of any SMI. Numerous findings have been reported but even today there are no diagnostic laboratory tests for any mental illness. Without sufficiently specific or clinically useful laboratory tests, Psychiatry will probably remain a 'provisional' medical specialty in the opinion of medical peers. The only effective response to criticism/disrespect based on this perceived shortcoming is to come up with the goods. Merely drawing attention to the negative effects on recruitment is unlikely to improve respect or recruitment. A better strategy might be to discuss the matter openly with students and interns on rotation through Psychiatry. The absence of diagnostic tests will probably always be evidence of an 'unscientific' specialty in the minds of technologically minded students but may not be a significant disincentive to students with an interest in mental illness.

The perceived ineffectiveness of treatment, particularly the treatment of SMI, has also been identified as a factor contributing to peer disrespect and vocational disinterest (Lee, Kaltreider, & Crouch, 1995). However a large number of medical diseases are not treated better or even as well as mental illness and there is no rational justification for vocational disinterest or lack of peer respect in this regard.

The Psychiatrist Role Model

Role models can have an effect on recruitment (Wright & Carrese, 2002) and different psychiatrists have no doubt inspired individuals with an interest in mental illness to pursue a career in Psychiatry. Collectively, psychiatrists have not enjoyed a good role model image within or outside Medicine and may at times contribute to tarnishing their image by not regarding themselves as 'proper doctors' (Craddock, et al., 2008). A study in 1964 found that medical students regarded psychiatrists as 'confused thinkers and emotionally unstable...often as abnormal as their patients' (Bruhn & Parsons, 1964). Different studies since then have found higher rates of suicide, substance use/abuse, depression and 'stress' in psychiatrists (Firth-Cozens, 2007; Deary,

Agius, & Sadler, 1996; Myers & Weiss, 1987; Rich & Pitts, 1980). Psychiatrists are usually rated lower than other health professions in public opinion polls. There are more negative jokes about psychiatrists than other doctors and films often portray psychiatrists as derisory or variously sinister characters. Posen claims that of all medical doctors, 'psychiatrists receive the most negative treatment at the hands of writers of fiction' and further suggests that negative perceptions of psychiatrists which have not changed in 100 years, are, at least in part, responsible for some early negative career choices (Posen, 2009). Walter undertook an analysis of the 'mad psychiatrist' stereotype and suggested that 'without indicating the direction of effect, the stereotype might be expected to have some bearing on the numbers and types of persons entering the profession' (Walter, 1989). There is no evidence of an important bearing of numbers insofar as recruitment has varied widely over the years despite much of the same negative perceptions if not stereotype. Walter's suggested effect of the stereotype on the type of person entering Psychiatry is a little puzzling. It is understandable that the stereotype might turn some individuals off Psychiatry. It is more difficult to understand in what way the stereotype of 'mad psychiatrist' might have a bearing on the type of person entering Psychiatry. It would not be surprising if some individuals were attracted to Psychiatry for personal or family reasons. There is a relatively high prevalence of anxiety and depression in medical students (Bunevicius, Katkute, & Bunevicius, 2008) and it would be interesting to know what percentage of those affected choose Psychiatry as a career path compared to those not affected. From a wider perspective, the motives and personalities of individuals entering Psychiatry are likely to vary as much as those of individuals entering other areas of medicine even if there is evidence of group trait differences, for example between surgeons and psychiatrists (Deary, et al., 1996).

A better psychiatrist image might attract more recruits but there is no guarantee that it would and considering the long history of negative perceptions and the persisting stigma of mental illness, it might be difficult to promote a better image. Insisting that 'a psychiatrist is just like any other doctor' is unlikely to be effective, especially when there are reports (Firth-Cozens, 2007) that psychiatrists may be more psychologically 'troubled' than other doctors. Deary acknowledged that

there might be personality characteristics that dispose some people toward a career in psychiatry and toward stress but suggest that screening recruits in terms of personality or other psychological factors would not be useful or advisable (Deary, et al., 1996). It is likely to remain the case that only students with an interest in Psychiatry would regard a psychiatrist as a positive role model. Students with stigmatizing attitudes towards mental illness are unlikely to do so irrespective of how deserving a psychiatrist might be.

Changes and Challenges in the Workplace and Work

Psychiatry's jurisdictional control in the treatment of mental illness has been challenged from different quarters and it has been suggested that continuing jurisdictional changes will impact on recruitment:

'The consequence of psychiatry's loss of jurisdictional control has been a diffusion of mental health treatment among a range of professionals whose stature and authority are both substantial and growing. This is very different from the scent that psychiatry residents entered 30 years ago, and it foreshadows a still different one 30 years from now...an issue that...students need to consider in making their long-term career decisions (Cooper, 2003).'

Psychiatrists with 30 years experience know that working with a multi-disciplinary team today is different to what it was when they started. Psychologists, nurses and even social workers have read their DSM manuals and have no hesitation in commenting on a patient's diagnosis. Experienced nurses are often as knowledgeable as doctors about the dozen or so commonly used drugs and have no hesitation in suggesting changes in dosage or drug. Nurses have already been given restricted prescribing rights in different parts of the world and it is probably only a matter of time before the same or similar rights are extended more widely to nurses and clinical psychologists. Practically all of the psycho-social treatment in the public sector is done by psychologists, nurses, occupational therapists and social workers – and nurses are becoming increasingly involved in the management of psychiatric presentations to ED. With these developments a growing number of psychiatrists in the public and private sector have confined their direct involvement in treatment to pharmacotherapy. This is a radical shift

away from the close doctor-patient relationship that characterized clinical practice in the past and it can be expected that the wider adoption of health service programs such as 'managed care' and 'capitation' will further lessen direct patient contact. The expectation in these developments appears to be that psychiatrists will focus on SMI and confine their role in treatment to pharmacotherapy and the planning/supervision of comprehensive treatment programs. Arguably the depth and breadth of clinical training and experience makes a psychiatrist the most qualified leader/supervisor of the multi-disciplinary team but not everyone agrees and the growing involvement of consumer/carer groups in treatment may contribute to more leadership challenges in the future. Some changes in the role of psychiatrist in the multi-disciplinary mental health team seem inevitable and it may be that with increasing encroachment on its jurisdictional domain, Psychiatry will establish closer links with neurology (Reynolds, et al., 2009) and/or focus on Neuropsychiatry and Liaison Psychiatry. This might make students perceive Psychiatry as being more in line with other disciplines and reduce negative perceptions. At this stage it is difficult to predict the impact of jurisdictional changes in Psychiatry and on recruitment. Students and graduates may see developments that leave them with doubts about the work satisfaction they will experience in Psychiatry even if they have an interest in mental illness. One the other hand students with true vocational interests in mental illness may not be deterred.

Summary and Conclusions

Recruitment in Psychiatry may improve in the short term because of the high prevalence of mental illness, a global demand for psychiatrists, a pool of international graduates willing to work in Psychiatry and an increasing number of graduates competing for other specialty positions. The concern is that short term gains may be more a reflection of expediency than genuine vocational interest. It is difficult to predict what will happen in the longer term. The growing involvement of non-medical disciplines in the treatment of mental illness may lessen the need for psychiatrists and further challenge the role of the psychiatrist in the mental health team. Such developments in combination with a growth of 'managed care' and other population based health programs

are likely to have undesirable consequences for psychiatric practice and recruitment. Psychiatrists can justifiably retain a key role in the treatment of SMI and psychopharmacology in general. They can also widen their clinical boundaries and consolidate jurisdictional authority with greater involvement in neuropsychiatry and consultation-liaison Psychiatry. Closer links with neurology might also be established. Such shifts in interest and affiliation are likely to appeal to a certain percentage of students who would then perceive Psychiatry as more in line with other medical specialties. The concern would be that efforts to make Psychiatry conform to other specialties will lose what is unique to Psychiatry and what appeals to graduates interested in mental illness, namely, the mental aspect of mental illness. The suggestion here is that the current emphasis on biological reductionism and marginalisation of competing theories of mental illness is not in the best interests of Psychiatry or recruitment. Psychiatry should do more to cultivate a culture of cooperative pluralism that may make it more attractive to today's and tomorrow's generation of graduates. Today's simplistic 'biological' Psychiatry is unlikely to evoke vocational interest from students with an appreciation of the more complex issues involved in mental illness – the kind of students who might advance Psychiatry and no merely see it as a means of making a comfortable living. Desirable vocational interest and selective recruitment may not increase without reforms in Psychiatry's quasi defensive retreat to reductionist agendas and avoidance of critical discussion on unresolved theoretical issues.

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