# Correspondence

## The culture of enquiry

Sir: The group of senior Registrars writing in the Bulletin (January, 1997, **21**, 57) about independent enquiries demonstrate a laudable wish to learn from enquiries into psychiatric catastrophes. Perhaps I could let the membership know how the College currently deals with such enquiries.

The first point is that at any one time there are between 30 and 40 such enquiries taking place. The vast majority of these say exactly the same things as all the others which have taken place. The Zito Trust recently published a review, 'Learning the Lessons: Mental Health Enquiry Reports 1969–1994', published January 1994, of all these enquiries which very helpfully brought together the recommendations and demonstrated how repetitive they were.

However, it is clearly necessary for the most serious enquiries to be looked at carefully by the College. It is not only the Clunis enquiry to which we have reacted. The Ashworth enquiry was also responded to vigorously and is the subject of a Council Report. I might at this point suggest that it would help trainees if all psychiatric libraries had a full set of Council Reports, and a regular order for all new Council Reports. This would help trainees to keep in touch with the thinking of Council on important topics.

All of the more serious independent enquiries are referred to Public Policy Committee for discussion and, where appropriate, action is taken either through the policy or the educational structures of the College. An example of this is the request in the Clunis enquiry report that the College should produce simple guidelines on Risk Assessment. Not only have we recently published a small pocket book (CR53), which you should all have received, but we are in the process of developing our first clinical practice guidelines on the management of violence in clinical settings.

Thus, although it may not be immediately obvious, the College is aware of independent enquiries and is, sometimes with difficulty, extracting the important points and acting upon them.

Finally, there is now widespread discontent with the system of independent enquiries as it currently exists. The College is making vigorous representations to the Department of Health to change the system without losing the essential watchdog function, which some sort of enquiry can serve.

PROFESSOR C. THOMPSON, *Registrar*

## Doctors and occupational health services

Sir: Your recent editorial on ill doctors discussed helping mechanisms (*Psychiatric Bulletin*, October 1996, **20**, 577–579). I was disappointed to see occupational health (OH) services characterised as 'not . . . reliable or useful'. I am unaware of any evidence that would support such a sweeping generalisation.

I was somewhat reassured that Professor Kessel characterised doubts about the confidentiality of occupational health services as 'unfair'. Again there is no evidence to suggest that this is a problem in OH departments and in the study of doctors' health and need for services, published by the Nuffield Provincial Hospitals Trusts, only a small minority of doctors expressed such concerns, even when asked directly.

The Faculty of Occupational Medicine, uniquely among Royal Colleges and Faculties, publishes specific ethical guidance to its members on the sometimes difficult question of confidentiality and employers. This ethical point is a specific part of specialist training for occupational physicians. Breaches of confidentiality are more likely to arise by accident and it is other clinicians whose training has not included specific aspects who give rise to concern.

The Faculty seeks the support of all clinicians in seeking to ensure that there is a specialist OH service available to all who work in the National Health Service. The Department of Health policy is that all NHS employees should have access to a specialist occupational health service though they decline to provide specific funds to achieve this aim. Nevertheless, over 80 consultant occupational physicians do work in the NHS and the numbers are increasing.

I believe that sick doctors could be helped enormously by access to properly staffed occupational health services where the important relationships between work and health can be dealt with appropriately and in a caring

confidential environment dedicated to helping them continue in practice.

KIT HARLING, *Dean, Faculty of Occupational Medicine, Royal College of Physicians, 6 St Andrew's Place, London NW1 4LB*

## CPD and the Fellowship

Sir: I have previously raised the issue of the Fellowship in these columns. CPD is also causing concern among members of the College. I would like to suggest linking these two processes. The Fellowship is currently a self-perpetuating oligarchy which cannot be justified on a democratic basis. I propose the following:

(1) Fellowship be awarded following the completion by a member of the College of two consecutive 3-year cycles of CPD.
(2) Fellows who fail to complete two 3-year cycles of CPD in any 9-year period should lose the Fellowship.
(3) Honorary Fellowships may continue to be awarded.
(4) Fellows who retire from active practice would continue to use the title of "FRCPsych (ret'd)".

This proposal would have the merit of linking Fellowship to an objective measure of one's commitment to continuing education and would also allow continued links with the College for members who are not practising primarily in psychiatry.

ADAM MOLIVER, *Consultant Psychiatrist, East Gloucestershire NHS Trust, Charlton Lane, Cheltenham GL53 9DZ*

## Incapacity Benefit

Sir: I wonder if there are other colleagues whose patients have had substantial difficulties with the new Incapacity Benefit system. When it was first introduced in April 1995 I noticed little impact on my patients and was relieved that psychotic patients have generally been exempted from Benefit Agency Medical Service examinations. However, in 1996 I had a substantial number of out-patients with non-psychotic depressive illnesses taken off Incapacity Benefit by Benefits Agency Medical Service doctors (BAMS). In most cases this has caused them substantial distress and has led to a deterioration in their depressive condition.

In the majority of cases I have felt that suspension of benefit was not justified. Patients who have appealed have obtained copies of the Benefits Agency Medical Officers' report form as part of the appeal process and I would have had little difficulty, for most, in giving a substantially higher score than the Benefits Agency Doctor. I have accordingly written reports to support several of these appeals. I understand that 15 points are required to qualify for benefit on mental grounds, assessed by a special questionnaire for mental symptoms.

I wonder, therefore, if there has been a policy by the Benefits Agency to target this group and I feel that, if there is, the College should be active in making its protest felt on behalf of our patients. There is clearly no reason, other than saving money, to harass individuals in their 50s who have taken early retirement on medical grounds and who have no realistic chance of working again. The aim seems simply to pressure them to stop claiming benefit altogether, which also I believe obliges them to pay a non-employed national insurance contribution until they reach pensionable age.

I would be most interested to hear if other psychiatrists have had similar experiences, as have several of my local colleagues, and if the College has any comments.

PHILIP D. MARSHALL, *Consultant Psychiatrist, Cefn Coed Hospital, Cockett, Swansea SA2 0GH*

## Postgraduate training and overseas experience

Sir: I write this letter with the idea of bringing to light the general disadvantage that overseas trainees in psychiatry are faced with when compared with other specialities. Having had my basic training in India, I had to pass the PLAB (Professional and Linguistic Assessments Board, conducted by the GMC) examination as did a few of my colleagues in other specialities in order to undertake further training in this country.

However, 18 months down the line I find that my colleagues have successfully passed the MRCP or FRCS and are now either Specialist Registrars or at least eligible to apply for such a post. However, due to college requirements (Royal College of Psychiatrists, 1996) I have only just been deemed eligible to sit the Part I, which I did in October 1996. I find myself faced with the prospect of working as a SHO for 2 years more, or one at the very least if the College decides to accept my overseas training. Given the fact that present Home Office regulations allow four years' permit free training, the best case scenario for me at the end of that period would be that I would have passed the MRCPsych II. On the other hand my colleagues may have been able to complete SpR training and be eligible for a CCST in their speciality.

I propose that overseas graduates be given the choice of sitting the Part I in the first 6 months in