acquired a much larger following in the West than in India. Gurus and their disciples are found in all walks of life and at all levels of education and sophistication. There is probably no other culture (with the possible exception of some ardently communist countries, notably China) in which so many of the population devote so much time to self-betterment. Yet it is surely the expression of a similar desire for self-betterment which prompted so many middle-class Americans to undergo costly psychoanalysis during the immediate post-war decades.

Regrettably, one has to admit that there is little firm evidence that either meditation or religious observance significantly modifies the incidence of mental disorders. Nevertheless, tens of thousands of Indians, young and old, have become disciples of teachers who support them in their twofold ambition to practise right conduct in accordance with Hindu *dharma* and to enhance their personalities by following a particular technique of meditation. If it could be established, with appropriate controls, that changes in symptoms and in personality traits do come about, and in the desired direction, then the possibility of collaborating between psychiatrists and Gurus could be worth exploring.

In concluding this account I should like to record what a pleasure it has been to work with Professors J. S. Neki, N. N. Wig and R. L. Kapur* and their respective colleagues, and what an especial pleasure it has been to find their post-graduate students so hard-working, so eager to learn and so cheerful, even when carrying extremely heavy clinical loads in the crowded out-patient clinics where the greater part of Indian psychiatric care is deployed today.

*The *Journal* from time to time publishes papers from them and their teams.

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Report of a Conference on Private Consultant Practice

By Kenneth Granville-Grossman, St Mary's Hospital, London

In March 1980 the British United Provident Association (BUPA) held its second residential weekend for consultants and senior registrars who had recently started in private practice or who intended doing so. About 70 consultants and senior registrars participated, including less than a handful of psychiatrists.

The need for private medicine

The first session was devoted to the need for private medicine from the points of view of both patient and doctor. That there was an increasing demand from patients for an independent sector was clearly demonstrated by the growth of private medical insurance. The demand was increasing at a current rate of 19 per cent per annum.

The need of the profession to practise independently of the State was also argued, one reason being that the NHS did not give many doctors the facilities to practise at as high a standard as they would like nor to treat their patients on a one-to-one basis, particularly in those branches of medicine (including psychiatry) where treatment by a multi-disciplinary team was the rule. One speaker felt that it was important for him to be in control of at least part of his professional life—in the independent sector he could work hard knowing that if he were dissatisfied he had only himself to blame.

For many doctors private practice meant more money, though there was, however, a general agreement that few doctors would earn in practice anything like as much as their counterparts in Europe and the United States. One speaker pointed out that in some specialties (including perhaps

psychiatry) financial needs might be better satisfied by spending time in non-clinical activities (for example, writing or conducting trials for drug firms).

The new consultant contract

It was pointed out that the new consultant contract (Personnel Memorandum PM(79) 11), published in November 1979, was a positive encouragement to private practice. Whole-time consultants could now earn from private practice up to a maximum of 10 per cent of their gross whole-time NHS salary (including any distinction award). Moreover the regulations allowed a consultant to exceed the 10 per cent limit for two years before being compelled to decide whether to limit his private earnings and change to a maximum part-time (10/11) basis. For most specialties, including psychiatry, expenses could be minimized by using NHS facilities to see private patients. Moreover there were important income tax advantages to having part of one's income assessed under Schedule D.

Private medical insurance

One session was devoted to health insurance schemes, particularly those available from BUPA. BUPA has a number of schemes—for individuals (notably 'BUPAcare'), for groups and for companies—all of which aim to pay for accommodation (nursing home and hospital) and nursing charges and specialist and other fees for in-patient care, but with very limited provision for out-patient or day care. Thus for those psychiatrists who have no in-patient private practice the insurance schemes help their patients in a limited way, and further there is usually no cover for charges for accommodation of patients who are presumably resident in a nursing home or hospital (thus excluding payment for long-term chronic psychiatric patients and for the elderly infirm). Professional fees are paid to 'specialists' only—a specialist being defined as a consultant at a recognized hospital (not necessarily NHS), although junior medical staff (for example senior registrars) who hold a certificate of specialist accreditation may also be recognized. Home nursing and physiotherapy are usually paid for, as may be the fees of medical ancillaries, including clinical psychologists, music therapists, lay psychotherapists, occupational therapists and social workers, but only when their work is being supervised on a day to day basis by a specialist.

There was considerable discussion of the implications of these schemes for current and future practice. Patients would reasonably expect consultants to charge within the limits of the benefits provided by the insurance company, and thus two types of private practice might emerge—one with modest charges for insured people and the other, not linked to insurance schemes, for the rich. Private insurance was also criticized for encouraging in-patient treatment; if benefits for out-patient and day care were increased, total costs could be brought down, because some patients would not be admitted to hospital.

Finance and taxation

A session was devoted to the financial aspects of private practice. This will not be summarized here as much of what was covered has been included in Mr Christopher Sandison's articles in *The British Journal of Hospital Medicine*.

Setting up in practice

Much of what was discussed in this session was of major relevance to the practice of surgeons, but some was of interest to other specialists, including psychiatrists. A number of speakers emphasized the relative paucity of facilities for private in-patients. Indeed the overwhelming majority of short-term beds in private hospitals and nursing homes are devoted to elective surgery and consequently it is often difficult to find private emergency accommodation. A psychiatrist pointed out that there were very few private psychiatric hospitals and nursing homes in the country, that some of these had their own consultants who took over the care of the patient from the referring psychiatrist, while very often private general nursing homes and hospitals would not admit psychiatric patients. Moreover psychiatric pay beds in NHS hospitals were virtually non-existent. Thus in many parts of the country there were almost no facilities for treating private psychiatric in-patients.

Fees were also discussed, and a psychiatrist pointed out that in a time-consuming specialty such as his he could not hope to earn as much as a physician, let alone a surgeon. Psychiatrists, it appeared, could reasonably charge £25-£30 for an initial consultation of one hour (more in central London). Initially, income from private psychiatric practice was bound to be limited, but with the new consultant contract there was no reason why a psychiatrist wishing to enter the private field should hesitate to do so.

Dr John Marks, a general practitioner from Hertfordshire, gave some very sound advice to all consultants in private practice. General practitioners, he said, were rarely involved in private practice and therefore expected a very high standard from private consultants. GPs preferred consultants who gave a good NHS service, who were readily accessible, who wrote informative reports, who charged modestly and who worked in collaboration with them. On the other hand, they did not care much for consultants who accepted self-referrals (even if followed by an apologetic letter to the GP), who asked the GP to write out NHS prescriptions, or who thought it necessary that the consultant should follow up patients with common conditions.

Conclusion

The course was thoroughly enjoyable and valuable. The organizer, Dr David Gullick, Executive Medical Advisor of BUPA, is to be congratulated for arranging the weekend so well and should be encouraged to put on further courses. Consultants and senior registrars in psychiatry, as much as surgeons and physicians, would undoubtedly benefit by their attendance.