Sick Doctors (Chapter 4)

The recommendations of the Report are endorsed. Where cases are referred to the Health Committee, the College would wish and expect to be deeply involved in a supportive and advisory role and also be involved in follow-up procedures. The College would call upon the expertise of its members in the Regional Divisions and on experts in the specialties.

Establishment of High Standards of Professional Conduct (Chapter 5)

While generally supporting the recommendations of the Report it is felt that the proposal (paragraph 371) for an annually issued practice certificate is neither practical nor desirable.

Composition of New GMC

The proposed constitution is acceptable provided that there is provision for wide consultation and the use of expert knowledge. It is felt that each constituent body will need to evolve machinery for providing its representative with information and for the representative to report back.

THE APPROVAL EXERCISE IN SCOTLAND*

By Kenneth Davison,

Consultant Psychiatrist, Newcastle General Hospital

The second stage of the College Approval (formerly 'Accreditation') Programme involving hospital visits was launched at the beginning of 1974. Each Division of the College appointed a Convenor and a panel of twelve visitors, and these are responsible for visiting the hospitals of another Division in batches arranged by the College office. Each visiting team consists of the Convenor and two panel members, and arrangements for each visit are made by the Convenor, local Clinical Tutor and the College Office.

The North-East Division of the College was given the task of visiting hospitals in Scotland, and I was selected as Convenor and provided with a panel of visitors. Whether by chance or design the latter showed a fine ethnic balance, as it contained two Irishmen, one from the North and one from the South, and two Scotsmen, one from the East and one from the West. Two Senior Registrars were also included and provided a particularly valuable contribution on subsequent visits.

I accepted the commission with a certain diffidence, as I wondered just how an Englishman coming to pronounce on Scottish institutions and methods might be received in these nationalistic times. In the event we could not have been received more courteously or hospitably.

The first visit took place in March 1974, and up to the present (Summer 1975) 22 hospitals or hospital groups have been visited. The ratings recommended by the visitors are as follows:

Category	*No. of hospitals*
A (full approval)	10
AS (limited approval)	7
P (provisional approval)	5

The Central Panel of Convenors subsequently reduced a recommended A to P and a recommended P to U (not approved). This last hospital has since been revisited and had improved sufficiently for the P category to be restored.

Our assessments were based on the ten-point College 'Statement on Accreditation of Psychiatric Hospitals and Units providing training in Psychiatry at the General Professional Level'. We looked for a clinical training that would complement theoretical teaching provided by an academic course. Ideally this would be based on general adult psychiatry with experience in acute admission, long-stay and psychogeriatric wards, supervised out-patient and general hospital consultation experience, community psychiatry, some supervision in group and individual psychotherapy and some exposure to mental handicap, child psychiatry and forensic work.

Clearly, few hospitals can provide all this experience. Our aim was to encourage the maximum use of the clinical material and facilities available, and this often entailed recommending that adjacent hospitals should combine resources. We preferred to approve rotation schemes rather than individual hospitals.

We looked for access to a reasonable library and reading room and liked to see at least one weekly local teaching activity in which trainees could take an active part, e.g. case conference or seminar. Trainees were expected to receive their study leave entitlement and not be overburdened with on-call commitments.

* Based on an address to the Scottish Division in May 1975.

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The Scottish psychiatric scene differs in several respects from that of England. The Physician Superintendent is still a power in the land, though if the ones we met were despots they seemed remarkably benevolent ones. Scotland has been less than enthusiastic about general hospital psychiatric units, so that the mental hospitals have not been starved of resources. The provision of consultants generally exceeds the DHSS norm of one per 60,000 population. No clinical tutor is paid and many lack official status.

There were some features which cropped up sufficiently often to cause us some concern:

1. There are obvious dangers for training in the system in which a consultant is responsible for in-patients of one sex only. We found some trainees who had dealt with in-patients of one sex only for periods of over two years. Where this system survives it is important to rotate the trainees within the hospital to allow experience in treating patients of both sexes.

2. We were surprised by the high proportion of registrars in some hospitals who were not psychiatric trainees but supposedly studying for higher qualifications in medicine, surgery, paediatrics or obstetrics. They are said to be needed as pairs of hands but they have a markedly deadening effect on psychiatric training within the hospital. This is a problem that could perhaps be examined more closely by the College.

3. We found instances of trainees being responsible at one time to five or six different consultants. We preferred the team system with a trainee attached to one or, at the most, two consultants at a time.

4. Many trainees, particularly from overseas, were not taking advantage of the academic courses available in University centres. Apart from geographical difficulties we thought the courses would be more attractive if they started with clinical psychiatry rather than the traditional basic sciences. Special introductory courses for overseas trainees may also be necessary. More could be done within the hospitals to teach interviewing skills and note-keeping.

Despite these criticisms we found a generally high standard of training in Scotland, and the clinical tutors were all devoted to their task. We endeavoured to make our criticisms constructive, and in subsequent correspondence with the tutors it has been apparent that our visits have often had a marked catalytic effect in bringing about changes in practice and organization that had been long in prospect. That is, after all, the object of the exercise.

OBSESSIVE-COMPULSIVE AND AGORAPHOBIC PATIENTS: A REQUEST

An MRC-funded research programme is examining the effects of clomipramine or placebo combined with behavioural treatment in patients with obsessive-compulsive disorder who are prepared to be in-patients for 7 weeks. Out-patients with serious marital discord plus agoraphobia are also being studied with behavioural treatments. Enquiries about referrals may be made to Dr. Isaac Marks at the Institute of Psychiatry, Maudsley Hospital, London, SE5 8AF.

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