Correspondence

The Approval Exercise

DEAR SIRS

As I have recently been involved in the College's Approval Exercise as a Panel member, I was particularly interested to read Paul Bridges' article, 'The Trials of the Convener of an Approval Team' (*Bulletin*, August 1982, **6**, 132–34). I recognize in that account a number of similar experiences and feelings, but it is from the standpoint of a Senior Registrar on a visiting team that I would like to put forward the following views.

Each College Division has a Convener who organizes the Approval Team for any particular visit. The Team is made up of the Convener and two other members, one of whom may be a Senior Trainee. The Senior Trainee's name is taken from a list, supplied by the Junior to the College Divisions. At present the Convener may decide to include a Senior Registrar or may complete the Team with two further Consultant members. A recent survey by Philip Thomas (*Bulletin*, July 1982, **6**, 124–25) suggests almost half of visiting panels do not include a Senior Trainee. My own view is that Trainee membership of the Approval Team should not be discretionary in this way, but should be an accepted and necessary feature of all Approval exercises. A Senior Registrar in this situation not only has an important representative function but, I feel, can make a unique contribution to the Approval exercise.

One of the main tasks of the team is to interview the SHOs/Registrars, as it is they who are being trained. This can be a delicate operation as some trainees see the Approval Exercise in terms of possible threat to their own careers. Even when assured that any alteration in Approval status for the hospital will not affect their personal training recognition by the College, there remains a reticence to air criticisms in front of outsiders. This may be because of fear, but more commonly loyalty is the reason. During my visits the Juniors were interviewed by the whole team and then by myself either singly or in groups. I found that the trainees were more likely to be forthcoming in discussion with the SR panel member than when consultant panel members were present. This is hardly surprising for an SR will recently have been at a similar stage in training.

There are other benefits: I found the informality of the meetings stimulated a two-way interchange of views, ideas and information. Training is not a passive process, and learning how trainees from other areas can help themselves in terms of organization and education can be invaluable. These meetings made me more aware of the function of a Senior Registrar in this process, particularly in the periphery. The SR is a little like an older sibling, accessible for informal discussion and near enough to the examination system to provide practical guidance.

Broadening the base of opinion included in the team may have advantages. This appears to be particularly relevant when considering the sometimes conflicting pressures of educational and service needs. An SR is more likely to perceive this issue from the point of view of trainees' needs, whereas a consultant member of the team is more likely to identify with the position of a colleague organizing a service and the practical difficulties this entails. The Senior Registrar and Consultant members therefore can provide a much needed counterbalance for each other when assessing a hospital for Training Approval and making recommendations.

I have discussed the contribution of an SR to the approval exercise, but I also feel that being a member of a visiting team provided me with a very useful educational experience. It forced me to think about the practical problems involved in the production of a relevant and comprehensive training programme. I have been given the opportunity to meet trainees from other areas and been made more aware of the Senior Registrar's role in providing a focal point for trainees and their needs.

I am not sure why there is not a Senior Trainee on every visit. Maybe it's because the Approval Exercise can stir up many emotions and when there are difficult areas to discuss the attitude is: 'not in front of the Juniors'. Whilst this is understandable, as all psychiatrists know, if there are problems to be discussed in a family, everyone needs to be there. After all, most of us will hopefully be 'parents' one day.

STEPHEN FROST

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DEAR SIRS

It was with great interest that I read Dr P. Bridges' article (*Bulletin*, August 1982, **6**, 132–34), as it provided a valuable insight into the workings of a Royal College Approval Team.

While agreeing that, of course, this exercise must be carried out in order to try and maintain and improve the standard of psychiatric training, I do sometimes feel that the recommendations made, concerning increase in staff, improvement of facilities, etc., are quite unrealistic in the present economic climate. I have seen a hospital given a 'P' approval (Provisional) with the hope that the local authority would provide the finance necessary to implement some of the recommendations. This finance was not forthcoming, and as certain recommendations could not be implemented (in particular the formation of new posts), the situation in which the Approval Team found the hospital on its return visit led to the award of a 'U' category (Unapproved).

In his article, Dr Bridges fails to mention the fate of hospitals or training schemes receiving 'U' status; perhaps they sink slowly into oblivion or does the College still believe that their decisions will stimulate drastic changes in regional planning and finance policy?

I feel that the award of a 'U' category puts a hospital in a 'Catch 22' situation; without Approval they lose the training posts and the standard of junior staff falls, but without a training scheme they cannot regain Approval from the College.

Finally, while criticism of schemes is often directed at consultant and teaching staff, let us remember that those most affected by the decision are the junior staff, whose careers are suddenly jeopardized through no fault of their own, and the patients, who are perhaps most likely to suffer in the long run. Surely, it must be better for all if the College makes constructive criticism taking into account local difficulties and offers to help hospitals to fulfil the College's requirements and to get back to the important task of training future psychiatrists.

S. EDWARDS

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Falklands aftermath: psychological casualties

DEAR SIRS

During routine clinical work in the University Department of Psychiatry at the Western General Hospital in Edinburgh we observed that during the Falklands Crisis the presentation of several patients with psychiatric disorders was influenced to varying extents by this distant conflict.

Two of our patients were depressed; one having made a suicide attempt because of worry about the loss of so many young lives in the Falklands and another became so concerned about this war, that it dominated her depressive thoughts. Yet a third had been referred because of a head tremor present for 30 years since the Korean War. This patient told us that the Falklands Crisis brought back memories of his own traumatic war experiences and that the present loss of life was now particularly abhorrent because war had never formally been declared. It seemed possible that the additional anxiety that had caused this referral was related to his worry about the Falklands conflict itself. A further patient suffered from an anxiety neurosis associated with a belief that an intense catastrophe was imminent (catastrophobia); his most recent preoccupation being the conflict in the Falkland Islands. A fifth patient had a more lengthy psychiatric history than the others and had the belief that Britain was now ruled by Argentina.

Initially it surprised us that this limited and distant conflict should nevertheless have had this influence on our patients. We thought this might be explained by the remoteness of the conflict itself and the consequent helplessness of many in influencing its course. It also seemed likely that for some it reawakened painful memories of previous wars and some unresolved grief. We wondered whether our experience in Edinburgh was unusual or was shared by other psychiatrists working elsewhere, and more especially by psychiatrists with longer memories of earlier wars?

LINDA MACPHERSON
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Western General Hospital and
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Psychology of nuclear disarmament

DEAR SIRS

I believe there is a considerable number of College members who are concerned about psychiatric problems related to nuclear war.

These would include aspects related to the effects of nuclear war, i.e. psychiatric casualties, the planning of services to deal with them, and issues related to the psychological stress of living under the threat of nuclear war. Also included is the question of whether psychiatrists have any expertise to contribute (or any responsibility to do so) to the difficult area of prevention.

Can I suggest that the College sets up a working party to study and report on this most important topic. It could benefit by being a joint one with the British Psychological Society as many of the issues are intricately linked with broader psychological ones.

I hope that any members who are interested will write to me so that I can use their support when raising the matter with the College.

JOHN GLEISNER
Secretary
Medical Campaign Against Nuclear Weapons
37 Alan Road,
Manchester

DEAR SIRS

The distinction between healthy fear of nuclear war and the marked preoccupation of doom in mental illness was well made by Jeremy Holmes (*Bulletin,* August 1982, **6,** 136–38). The fact that fear is appropriate and can provide a motivation for seeking safety is the psychological basis of the strategy of defence-by-threat that is called deterrence. Because people habituate to fear, the strategists have progressively increased the threat by increasing the risks. Assuming that the population of Britain is not intended as the principal victims of this fear, the psychology seems as naive as the belief of an addict that increasing his dose can perpetually postpone withdrawal symptoms.

Whatever the intention, a defence policy based on nuclear