Aggressive patients are not peculiar to psychiatry; doctors in accident and emergency departments may be more exposed to violent patients. However, the systematised threatening from some paranoid patients can be worrying and the amount of aggression towards trainees by patients is another subject both senior and junior psychiatrists are often reluctant to discuss.

(3) *Personal issues*

The difficulties involved in working in teams with persistently questioning and critical non-medical colleagues is one frequently mentioned by trainees. This occurs much less often in other specialties.

Regrettably senior medical colleagues may also be seen as critical and over-demanding rather than supportive and constructive by some trainees. Although this is hardly peculiar to psychiatry, it is resented in our specialty perhaps because psychiatrists are expected to be more patient and understanding than other specialists.

Psychotherapeutic methods may give rise to self-doubt and questioning in the trainee. Macaskill (1988) has described this in doctors undergoing personal analysis. Many junior doctors prevent potential discomfort by avoiding psychotherapy experience and this is sometimes condoned by clinical tutors and even psychotherapists themselves. My own view is that no-one can be regarded as a fully-trained psychiatrist without well-supervised psychotherapy training and experience and that dealing with the feelings and stresses produced by this is an essential part of the unique learning process involved in becoming a psychiatrist.

I have not dealt with the important but separate issue of who should counsel. *Achieving a Balance: Plan for Action* does, of course, suggest a sequence of consultant, clinical tutor (and/or specialty or College tutor) and post-graduate dean. This reflects current practice in most areas although district clinical tutors report little contact with trainee psychiatrists and post-graduate deans are usually directly involved with counselling only a minority of doctors.

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## *Career counselling of overseas doctors*

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The days have gone when medical graduates could safely assume a relatively trouble-free progression in the career of their choice. The shortage of medical graduates and expansion of the National Health Service in the sixties and seventies created a scenario which not only allowed UK graduates considerable choice and ready promotion but sucked in a large number of doctors from third world countries who arrived here with the aim of obtaining training and medical and surgical diplomas much prized in their countries of origin. The absence of training in psychiatry at undergraduate level as well as low prestige and limited opportunities for private practice in psychiatry in the country of origin meant that the majority of third world doctors arrived in the UK to train in other branches of medicine. Many, however, found it difficult to pursue their original objective and gravitated towards other branches of medicine including psychiatry. In other words, market forces were already operating before the term came into common usage, bringing in a supply of labour to an expanding market: having arrived, further stratification then took place.

By the early seventies concern began to be expressed about the competence of many such doctors, and the Merrison Committee in 1975 made several recommendations requiring overseas doctors to take a test of professional competence at the level of Senior House Officer as well as a test of formal and colloquial English (PLAB). In spite of this screening procedure to ascertain minimum levels of competence of overseas doctors from third world countries, doubts still lingered in the minds of many regarding the overall competence of these immigrant doctors. Overseas doctors therefore have been perceived as being "less than full" physicians – a concept which has widespread and serious implications. The professional and cultural competence of these doctors is a critical gate-way to other forms of learning. The doctor who is regarded as less competent in these areas may, in the end, become less competent as he will receive a lower quality of education.

There is an ambivalence about the presence of overseas doctors in the National Health Service and our historical dependence on them even though they have often fulfilled a residual role in taking up posts which were not sought by indigenous graduates. Many overseas doctors who are working in the NHS will be facing the dilemma of whether or not to return to their country of origin. The decision not to return may be influenced by political factors or financial and professional considerations. Having practised

psychiatry in the affluent part of the world the doctor 'learns' to expect a certain standard of provision of facilities to care for his patients which may or may not be available back home.

That doctors trained overseas are disadvantaged in competition for jobs within the National Health Service cannot be denied (Smith, 1987). The evidence is beginning to harden that racial discrimination contributes to overseas doctors having trouble in obtaining appropriate posts. Yet, 'race' is rather difficult to define biologically and people often talk about race and ethnic groups interchangeably. Prejudice has been defined as being "prejudgement, deciding something in advance". Prejudgement becomes prejudice if it is not subject to modification. The major characteristic of a prejudiced person is the mental rigidity that the prejudiced person maintains by twisting new information to accord with stereotyped pre-supposition. Racial discrimination based directly on race or colour, while it does occur in medicine, is often difficult to prove and requires great courage – or perhaps foolhardiness – on the part of the person who gives evidence about the discrimination. Indirect discrimination however is difficult to pin-point and may not even be perceived by those who are practising it. Newsam (1986) gives an example of an all white committee or a company recruiting employees by word of mouth or recommendations. The minority are often shut out even though there is no direct intention to keep them out –the system achieves this. Indirect discrimination then becomes a crime without villainy. Irritation with immigrant doctors is often justified with statements such as, "Isn't it better for them to return to their own country, they need doctors there". In private conversation some even argue that, "How can Newcastle be the natural home of an Indian?" To paraphrase Newsam, "Where is the natural home for several thousand (white) people who emigrate to South Africa each year?"

Let us therefore look specifically at the overseas doctors who, for the purpose of this article are 'black' doctors from third world countries: the progress of overseas doctors who are white and from such countries as Australia does not appear to be impeded. The term 'black' here is used in the political sense and represents mainly Asian doctors, there being fewer Afro-Caribbean doctors. Broadly speaking the overseas doctors can be categorised in three groups: the first group are sponsored overseas doctors who come to the UK for specific training and are funded by their countries or the UK government and return after a stipulated period. The second group are the largest group of doctors who arrived in the UK prior to April 1985, who have chosen to stay and may be encountering difficulties. The third group are the doctors who have arrived after the April 1985 regulations came into force and whose maximum training period in the UK may not exceed four years at the end of which time they must leave the UK. The doctors who may need career counselling are those who have a right of residence and have decided to take this option; they may or may not have been successful in obtaining post-graduate qualifications.

Having identified the 'target' group, let us look at those who are in the position to help or offer counselling. Counselling is concerned with the individual's adjustment to themselves, the significant others in their lives and the cultural environment in which they find themselves. The counsellor therefore needs to sensitise himself and be aware of the wider context of the organisation of which he or she is a part. He will need to reflect on his own attitudes and be aware of racism as a factor which might colour his attitude as well as being aware of institutional racism which may have contributed to the inequalities which persist. He may need to ask the question "Do overseas trainees have a real choice and would they as 'black doctors' really choose to approach a counsellor who represents the authority of a white institution which they may perceive as being racially biased?" Does this mean that overseas trainees need positive discrimination or should we wait, leave them alone and hope that they go away?

My own view is that the senior staff, i.e. heads of departments, course organisers and tutors, have not been particularly interested or effective in reducing or abolishing the inequities which exist in the system until now. The trainee has the further problem that those people who will be offering counselling are also people in posts of authority and power and could not be described as independent counsellors. There is therefore a need for the profession to consider the appointment of a senior and respected person at a Regional level to take a particular interest in overseas trainees, not only offering them career counselling and individual help but, if necessary, acting as their advocate. His/her guidance will be sought freely once it becomes evident that he/she is acting as the chivalrous champion for whom they have long been waiting.

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