



# the columns

## correspondence

### Protected research sessions

There has been considerable recent discussion about the strengths and weaknesses of the protected research sessions enjoyed by specialist registrars (Petrie *et al*, *Psychiatric Bulletin*, May 2004, **28**, 180–182).

The College feels that 'There is probably no better way to obtain insight into these matters (i.e. research) than to undertake a piece of original research' and, in practice, the aim of these sessions has been seen as the publication of research in peer-reviewed journals.

There are high levels of dissatisfaction with this system, and many problems have been identified as preventing specialist registrars from using this time effectively. Obstacles to the production of original research include deficiencies in motivation, supervision and training (Vassilas *et al*, *Psychiatric Bulletin*, August 2002, **26**, 313–314).

An excellent use for these research sessions is the undertaking of a relevant postgraduate degree. There is a wide variety of such courses, many of which provide training in research methods as well as supervision. Motivation is provided by the knowledge that original research, often in the form of a dissertation at the end of the course, is a mandatory requirement for the awarding of the degree.

Completion of relevant postgraduate degree courses with a research component should be seen as a valid use for research sessions.

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### Psychotherapy training

Janmohamed *et al* examined the impact of training arrangements in one large scheme on senior house officers' expectations of meeting College guidelines for psychotherapy training (*Psychiatric Bulletin*, March 2004, **28**, 100–103). In September 2003, clinical tutors across the West Midlands assisted with an audit of training opportunities and part II MRCPsych candidates' actual compliance

with current guidelines. It showed that logbook records of psychotherapy experience were often inaccurate. Where availability of supervision was relatively good, this did not guarantee good take-up.

Thirteen candidates could be fully assessed against the current guidelines for supervised practice (Royal College of Psychiatrists, 2002). They were most likely to have received supervision for brief individual psychodynamic psychotherapy and least for group psychotherapy. Supervision experience in cognitive-behavioural therapy was more common than in brief integrative or supportive therapy (which the current guidelines also require). Four trainees were effectively prevented from getting near the total requirement because they did not receive family therapy experience when rotating to posts in child psychiatry. Most trainees had not managed to see the recommended 'long' case, and this requirement alone prevented three from meeting the guidelines in full. The only two who did fulfil them had both undertaken a full-time 6-month placement in psychotherapy within the previous year.

Janmohamed *et al* reported high support among trainees for rotational psychotherapy posts when protected time is already provided. When, as here, this protection is not well established, dedicated full-time or half-time psychotherapy posts remain a reliable means of ensuring current guidelines are met.

ROYAL COLLEGE OF PSYCHIATRISTS (2002) Requirements for psychotherapy training as part of basic specialist psychiatric training (<http://www.rcpsych.ac.uk/traindev/postgrad/ptBasic.pdf>).

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### Sharing information/ disclosure

As I so often read the 'yellow' journal or the *Bulletin*, I wanted to know why children are excluded from the issues discussed. In child and adolescent psychiatry, the issues of access to records

and copying of letters to patients have quite different dimensions. Children, as well as adults, have rights.

The additional dimensions are:

1. The child is our patient. What rights have the parents? This is obviously complex and often age or development-dependent, but children tend to be ignored. Children as young as 8 can be consulted, even if their views are overruled, as to whether they want clinical information disclosed to their parents.
2. Letters sent to referrers can be copied to children and adolescents. Younger children cannot read and, in most households, parents control the correspondence so the child may not receive the letter. Should children and parents be copied separately? Should clinics arrange to read out letters about the child to the child or adolescent?
3. There is the problem of possible harm to the child by copying clinical correspondence to his or her parents. Are letters to be worded to be most child- or parent-friendly? How is our duty to the child and to the parents balanced? For example, when we know a letter is to be copied, we may omit negative opinions about a parent and his/her care. From the child's perspective, should this be included? Looking at this the other way round, including an opinion about the possible detrimental effect of, say, the parent's negative approach to the child might increase the hostility.

I realise there are answers of a sort to all these questions – from human rights, legal and therapeutic perspectives – but I wanted to raise awareness of children in such discussions and raise the profile of children and their rights in psychiatric practice.

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### Evaluation of copying letters to patients

I agree with Geoffrey Lloyd's sentiments that much more evaluation will be required concerning the issue of copying



letters to patients (*Psychiatric Bulletin*, February 2004, **28**, 57). My view is that this represents the most intrusive incursion yet by this Government into the central relation between doctor and patient.

My objections to this policy are several. First, on clinical grounds, I am concerned about the impact of this policy on the welfare of my patients who are children. As a child psychiatrist, one often makes judgements about the nature of attachment relationships and parenting abilities in parents of the children one sees. Frequently, it is in the interests of the child that other health professionals are aware of such difficulties, but not necessarily the parents as this may significantly affect the engagement process.

It seems to me that there are two ways of dealing with the problem of sending copies of letters to patients: one is to leave out information altogether, which I would argue is not in the best interests of the child, and the other is to render the letters so euphemistic as to be meaningless.

Whichever way one chooses to manage this problem, it is clear that we shall be discouraged from the use of medical language: and here we can see the other motivation of the Government in the current political climate, which is to deprofessionalise doctors; in other words, we shall be 'dumbed down'.

The second of my objections is more practical and concerns the enormous administrative burden involved in responding to patients' objections,

queries, anxieties and sending out more mail: how is all this to be funded?

At a time when there are still great difficulties in delivering a decent health service to patients, it seems ludicrous that resources are being directed away from direct patient care to attempts at manipulating the public into believing that their health care is being improved by receiving copies of communication from their doctors. Is anyone really going to be fooled by this?

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### Mental Health Officer status

Mears *et al* (*Psychiatric Bulletin*, April 2004, **28**, 130–132) describe Mental Health Officer status as a 'perverse incentive'. This implies disapproval of the only perquisite ever to have been enjoyed by consultant psychiatrists and other disciplines working in mental health. It may well be that the recruitment into our specialty was enhanced by Mental Health Officer status opportunities, sadly removed, I understand, from new entrants several years ago.

My own Mental Health Officer status was removed without my knowledge when I became an academic. Although it has now been reinstated, the possibility of being obliged to work full-time for an

extra 5 years for financial reasons was a most worrying and unattractive one.

However, I am sure that Mears *et al* have got it right when they say that the reasons why consultants retire early are complex, multidimensional and highly individual. In my own case, the youngest of my three children will only be 12 years old when I am 55, and after having missed out on so much of my children's early years it would be quite nice to spend more time with them when they are older. Like most of the consultants participating in Mears *et al*'s survey, the most attractive prospect is to take early retirement but continue to work part-time in some other capacity. It is difficult to envisage any incentive that could overcome my desire to spend more time with my family, apart from reduced working hours for what is in effect the same pay, which is of course what you end up with by taking early retirement and then working part-time.

Perhaps an investment in allowing older consultants to reduce their hours while maintaining their salary would be worthwhile in terms of both retention of older consultants and in attracting new graduates to our specialty. However I suspect that there are many consultant posts in psychiatry, my own included, which could not be feasible on a part-time basis.

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