was a ruthless exploiter of his patients, as his needs moved him.

As might be imagined, all these events – and others, such as recent publicity about sexual relationships between doctors and patients – have done the medical profession's reputation considerable harm. Psychiatry has suffered most, for obvious reasons, and some of the responses that the Royal Australian & New Zealand College of Psychiatrists has made may be of interest.

Firstly, and importantly – since it is quite apparent that there have been serious departures from proper professional standards – the College has not fallen into the error of trying to persuade itself and others that there is really nothing to worry about. When the regulatory bodies began at last to take firm action – substantially because of the formation of the Complaints Unit of the New South Wales Health Department in 1984 – the College assisted in those actions and cooperated fully with the Royal Commission.

Before that, in 1982, the College formed a Clinical Standards Committee with the duty of considering material put before it by investigating bodies, such as coroners and hospital boards. Its responsibility was to inform the College Executive as to whether or not there had been a serious breach of professional standards: in every case, the Executive has transmitted the advice to the enquiring body. This activity is to be distinguished from quality assurance, which is concerned with the errors and imperfections that most psychiatrists manage to avoid most of the time.

In the past year, the College has reformed its structure, in that it has two substantial Boards, one concerned with getting into the College and the other with performance while a Fellow. The first of these is the Fellowships Board, which comprises the Examination Committee, the Committee for Training, and the Committee for Training in Child Psychiatry; their functions are apparent from their names.

The second is the Practice Standards Board, which comprises the Committees for Quality Assurance and for Continuing Medical Education, together with the Ethics Committee and the Clinical Practice Advisory Committee. The last named is the Clinical Standards Committee revised. There are, of course, other structures within the College concerned with special activities and interests, and there are also regional committees (the College is binational), but they are not related to this particular issue.

Not all the changes have been welcomed by all the Fellows. Some see any form of scrutiny or monitoring as a threat to their clinical independence, and others regard cooperating with regulatory authorities as supping with the devil. While one can empathise with their misgivings, the events of the last few decades in Sydney and elsewhere in Australia make it clear that psychiatry can go very badly wrong and that if we do not put our house in order, there are others who would be very pleased to do it for us.

We have also learnt that, in a sense, no news is bad news. That is, if in a large region there are no complaints of reprehensible behaviour, it does not signify that it is not present, but merely that it has not reached the light of day. The more carefully we examine ourselves, the more chance we have of protecting our patients and preserving our own reputation.

Lunchtime lecture

A lunchtime talk entitled 'From Trieste to Tennessee – therapeutic design for acute mental illness' will be given by Peter Barefoot at the Chartered Society of Designers, 29 Bedford Square, London WC1 on 19 November 1991. (Chairman: Dr Peter White). Further details: Nell Chamberlain, Design and Industries Association, c/o 17 Lawn Crescent, Kew Gardens, Surrey TW9 3NR (telephone 081 940 4925).

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