columns

changes proposed in Modernising Medical Careers and stringent record of in-training assessments, more trainees will have the opportunity to fulfil the training requirements and develop the basic psychotherapeutic skills essential for any competent psychiatrist.

We would like to propose that the College makes it mandatory that approval for a training post at SHO, specialist registrar, or even consultant level only be granted if the base hospital has a full-time or part-time consultant psychotherapist. This might apply much-needed pressure to some reluctant trusts and will certainly help to eliminate unequal opportunities which are currently present in psychotherapy in different parts of the country.

DHARMADHIKARI, A. R. (2006) Basic training in psychotherapy. (eLetter to *Psychiatric Bulletin*). http://pb.rcpsych.org/cgi/eletters/29/12/470-C

ROYAL COLLEGE OF PSYCHIATRISTS (2003) *Requirements for Psychotherapy Training as Part of Basic Specialist Psychiatric Training*. London: Royal College of Psychiatrists. http://www.rcpsych.ac.uk/PDF/ptBasic.pdf

WEBB, K. (2005) Changes in psychiatric education. *Psychiatric Bulletin*, **29**, 470–471.

***Rajasekar Basker** Staff Grade Psychiatrist, Lord Street Resource Centre, St Helens, Merseyside WA10 2SP, email: raashekar@yahoo.com, **Rohan Van der Speck** Senior House Officer in Psychiatry, Brooker Centre, Halton General Hospital, Runcorn, Cheshire, **Emad Salib** Consultant Psychiatrist, Stewart Assessment Unit, Peasley Cross, Marshalls Cross Road, St Helens, Merseyside

The International Fellowship Scheme and perinatal psychiatry services in South India

I chose to work as a consultant in Manchester under the International Fellowship Scheme, so that I could gain experience with a view to setting up perinatal psychiatric services in India. The trust accommodated my needs and I was able to spend time working in the perinatal out-patient service at Wythenshawe Hospital and running special services with a perinatal psychiatric nurse in communities around North Manchester. I learnt about child protection issues, pre-pregnancy planning protocols, risk assessments and liaison with general practitioners, nurses and obstetricians. I also had the luxury of caring for several mothers and their babies at home – a novel experience. Thanks to the Fellowship Scheme, my colleagues and I have been able to set up the first formal perinatal psychiatric service for women with severe mental illness in South Asia, at Bangalore. I have also received enquiries from two other female former International Fellows who want to set up these services in other parts of South India.

Mothers who I cared for while in the UK were sad that I was leaving but were happy that I was able to help them briefly and were happier when I told them that mothers in India would now benefit from similar services! I think that I have been able to bring back somthing valuable from the UK thanks to the Fellowship Scheme.

Prabha S. Chandra Professor of Psychiatry, National Institute of Mental Health and Neurosciences, Bangalore 560029, India, email: prabhachandra@rediffmail.com

Medical management and clinical leadership

Am I alone in finding a distinct irony in the publication of the first two articles in the June issue (*Psychiatric Bulletin*, June 2006, **30**, 201–203 and 204–206) – namely 'Medical managers in psychiatry – vital to the future' and 'Kerr/Haslam Inquiry into sexual abuse of patients by psychiatrists'? I note in the latter paper comments by Dr Kennedy regarding 'consultants being "all powerful" ' and that 'the report challenges the absence of a clear moral and contractual obligation for all mental health professionals to report all such information, and the lack of an NHS system to maintain an accessible memory bank of all such data. Will the professions fear this as a "big brother" scenario or welcome it as an essential protection of their patients and their credibility?' These comments are made immediately after an article by Griffiths & Readhead which champions the cause of 'medical managers' and which sets out clearly their views of how 'vital' this role is to 'psychiatry'.

In my opinion these two articles highlight the inherent danger of the move by the Royal College of Psychiatrists to appoint a vice-president to promote 'medical management' with the clear aim that we continue a 'medical model' of 'medical management' where psychiatrists in these roles are seen as having great influence at strategic board and other levels and indeed over other professional colleagues.

I would respectfully suggest that this move by the College reinforces the stereotype of consultants and of medical managers being 'all powerful', as highlighted by the Kerr/Haslam Inquiry. The reality is that if we as a profession are serious about leading services into the future and providing strategic direction, we should only be given this role if we are able to demonstrate the ability to provide clinical leadership to all clinicians working within mental health services. We expect psychiatrists to work and indeed provide leadership to multidisciplinary and often multi-agency mental health teams in a variety of settings, yet at College and other levels we continue to promote a model of 'medical management' rather than a model of clinical leadership.

My opinion is that if we are serious as a College in wishing to provide leadership in both the development and provision of services in the twenty-first century then we need to embrace models of clinical leadership in which consultants engage with other professionals and accept that being a consultant gives one no divine right to act in an all powerful, inappropriate way. It is unacceptable for consultants' behaviour to be challenged only by other consultants who are 'medical managers'. If these models of clinical leadership are not adopted I fear the 'failures' identified by the Kerr/Haslam Inquiry will only be repeated in the future. This surely is the challenge for psychiatrists interested in management roles in 2006, and the College should be promoting a model in which psychiatrists are selected for management roles on merit rather than simply because they are a doctor.

Alastair N. Palin Consultant Psychiatrist/Clinical Director, Grampian Mental Health Services, Royal Cornhill Hospital, Aberdeen AB25 2ZH, email: fiona.reid@gpct.grampian.scot.nhs.uk

Changes to the number of CCTs will have a positive impact on training

I read with interest the eLetter from the President and the Dean of the College about the proposed changes to the number of certificates of completion of training (CCTs) in psychiatry (http://www.rcpsych.ac.uk/pdf/chnagesMay06E.pdf). No doubt these changes will have a significant impact on the future of psychiatric training at a time when postgraduate training is undergoing a radical overhaul with the anticipated introduction of Modernising Medical Careers (MMC) in August 2007.

I believe that reducing the number of CCTs from the current six to two will be beneficial to trainees for a number of reasons. First, it will bring psychiatric training in the UK in line with the rest of Europe, where psychiatrists gain accreditation in either adult or child psychiatry. A major reason for the introduction of MMC was to streamline postgraudate training in the UK, which was considered too lengthy compared with the rest of the world. Second, as reported by Day *et al* (2002), many of the issues facing UK trainees are common to psychiatrists in training across Europe.

We have certainly taken the lead in establishing a structured system of training, but we need to continue

https://doi.org/10.1192/pb.30.9.353 Published online by Cambridge University Press