



the columns

correspondence

Regulatory burden in research

I would like to highlight difficulties we have experienced, in the hope that this will help others. We are taking part in a multicentre study which was approved by the multicentre research ethics committee in August 2005. In Bristol we are studying patients attending hospital clinics and a group from primary care.

Both site-specific assessments and R&D approval resulted in months of delays. Advice that we could not quote the primary care trust as a site (i.e. we needed to list surgeries that had agreed to take part) later turned out to be wrong. It was also unclear from guidance from the Central Office for Research Ethics Committees (COREC) that site-specific applications are not considered by the main ethics committee, but by subcommittees which meet more frequently.

Both R&D departments involved advised that an honorary contract was required prior to any patient contact, in addition to my NHS contract with the local mental health trust. An honorary contract with one was not acceptable to the other, in contravention of Department of Health guidance: 'where a researcher works across many NHS organisations they should not have to obtain multiple contracts' (http://www.bartsandthelondon.org.uk/research/honorary_contracts.asp). Both departments required separate Criminal Records Bureau checks and occupational health clearance, causing significant delays.

As an aspiring young academic psychiatrist this has been a discouraging start to my research career. There has been much debate about the regulatory and bureaucratic burden in research and the need to find a balance with safety so that research in the UK is not stifled. Sadly this does not seem to have been put into practice yet.

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Sexual abuse of patients by psychiatrists

I was pleased to read Dr Kennedy's review of the Kerr/Haslam Inquiry (*Psychiatric Bulletin*, June 2006, **30**, 204–206) and Dr Subotsky's response on behalf of the College (*Psychiatric Bulletin*, June 2006, **30**, 207–209). Dr Subotsky referred to sexualised behaviour between doctors and patients having been made criminal.

The Sexual Offences Act 2003 introduced significant changes to the law by introducing a new offence of sexual activity with a person with mental disorder impeding choice. This offence requires proof of sexual touching and that the individual was unable to refuse because of or for a reason related to a mental disorder. In addition, it must be proven that the perpetrator knew or could reasonably have been expected to know that the victim had a mental disorder (Stevenson *et al*, 2004). The key factor in determining whether it is possible to bring a safe conviction will hinge around capacity to refuse unwanted sexual activity. This is not defined in the Act (British Medical Association, 2004). For people with mental illness, where capacity is likely to fluctuate, it may be difficult to prove what their mental state was at the time of the alleged offence. Although well intentioned, in practice the law may be difficult to implement.

Clinicians should be aware that they or their colleagues may be arrested on a charge of rape should they decide to have sexual intercourse with their patients. Doctors will always be in the position of having more choice in these situations than their patients. For this reason, it is right that the College continues to deem that relationships of sexual intimacy between doctor and patient are totally unacceptable (Royal College of Psychiatrists, 2002).

BRITISH MEDICAL ASSOCIATION (2004) *Assessment of Mental Capacity – Guidance for Doctors and Lawyers*. London: BMJ Books.

ROYAL COLLEGE OF PSYCHIATRISTS (2002) *Vulnerable Patients, Vulnerable Doctors: Good Practice in Our Clinical Relationships* (Council Report CR101). London: Royal College of Psychiatrists.

STEVENSON, K., DAVIES, A. & GUNN, M. (2004) *Blackstone's Guide to The Sexual Offences Act 2003*. New York: Oxford University Press.

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Psychotherapeutic skills and College requirements

Pretorius & Goldbeck (*Psychiatric Bulletin*, June 2006, **30**, 223–225) commented on difficulties encountered by psychiatric specialist registrars in fulfilling the College requirements for experience of psychotherapy (Royal College of Psychiatrists, 2003). To determine the extent of the problem in Merseyside, we performed a survey of the psychotherapy experience of 73 trainee senior house officers (SHOs). Only 31 (42%) were aware of College requirements. Five trainees (7%) had conducted a long-term individual case and 41 (56%) at least a short-term case. Of those who had cases allocated, 21 (29%) had one short case, 11 (15%) had two short cases and 9 (12%) had three short cases or more. Of 11 trainees who sat their MRCPsych part II examination in March 2006, only 2 (18%) fulfilled the College requirements for psychotherapy experience. Only 14 trainees (19%) expected to fulfil the requirements by the time they were to sit their MRCPsych part II examination.

Of the 73 placements, 49 posts (67%) had supervision by a consultant psychotherapist. These included a Balint group, which most trainees had to do in their first two placements. The other trainees were not receiving supervision by a psychotherapist at the time of the survey. Our findings are consistent with those of Webb (2005) from Nottingham, Dharmadhikari (2006) from Leeds and Pretorius & Goldbeck (2006) from Scotland.

With the current 3- to 4-year training scheme it is difficult for trainees to fulfil College requirements. Pretorius & Goldbeck (2006) found that organisational changes have improved exposure to psychotherapy in different modalities. It is hoped that with improved planning, the



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>

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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 something valuable from the UK thanks to the Fellowship Scheme.

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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.

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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 postgraduate 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