confidential environment dedicated to helping them continue in practice.

KIT HARLING, *Dean, Faculty of Occupational Medicine, Royal College of Physicians, 6 St Andrew's Place, London NW1 4LB*

CPD and the Fellowship

Sir: I have previously raised the issue of the Fellowship in these columns. CPD is also causing concern among members of the College. I would like to suggest linking these two processes. The Fellowship is currently a self-perpetuating oligarchy which cannot be justified on a democratic basis. I propose the following:

(1) Fellowship be awarded following the completion by a member of the College of two consecutive 3-year cycles of CPD.
(2) Fellows who fail to complete two 3-year cycles of CPD in any 9-year period should lose the Fellowship.
(3) Honorary Fellowships may continue to be awarded.
(4) Fellows who retire from active practice would continue to use the title of "FRCPsych (ret'd)".

This proposal would have the merit of linking Fellowship to an objective measure of one's commitment to continuing education and would also allow continued links with the College for members who are not practising primarily in psychiatry.

ADAM MOLIVER, *Consultant Psychiatrist, East Gloucestershire NHS Trust, Charlton Lane, Cheltenham GL53 9DZ*

Incapacity Benefit

Sir: I wonder if there are other colleagues whose patients have had substantial difficulties with the new Incapacity Benefit system. When it was first introduced in April 1995 I noticed little impact on my patients and was relieved that psychotic patients have generally been exempted from Benefit Agency Medical Service examinations. However, in 1996 I had a substantial number of out-patients with non-psychotic depressive illnesses taken off Incapacity Benefit by Benefits Agency Medical Service doctors (BAMS). In most cases this has caused them substantial distress and has led to a deterioration in their depressive condition.

In the majority of cases I have felt that suspension of benefit was not justified. Patients who have appealed have obtained copies of the Benefits Agency Medical Officers' report form as part of the appeal process and I would have had little difficulty, for most, in giving a substantially higher score than the Benefits Agency Doctor. I have accordingly written reports to support several of these appeals. I understand that 15 points are required to qualify for benefit on mental grounds, assessed by a special questionnaire for mental symptoms.

I wonder, therefore, if there has been a policy by the Benefits Agency to target this group and I feel that, if there is, the College should be active in making its protest felt on behalf of our patients. There is clearly no reason, other than saving money, to harass individuals in their 50s who have taken early retirement on medical grounds and who have no realistic chance of working again. The aim seems simply to pressure them to stop claiming benefit altogether, which also I believe obliges them to pay a non-employed national insurance contribution until they reach pensionable age.

I would be most interested to hear if other psychiatrists have had similar experiences, as have several of my local colleagues, and if the College has any comments.

PHILIP D. MARSHALL, *Consultant Psychiatrist, Cefn Coed Hospital, Cockett, Swansea SA2 0GH*

Postgraduate training and overseas experience

Sir: I write this letter with the idea of bringing to light the general disadvantage that overseas trainees in psychiatry are faced with when compared with other specialities. Having had my basic training in India, I had to pass the PLAB (Professional and Linguistic Assessments Board, conducted by the GMC) examination as did a few of my colleagues in other specialities in order to undertake further training in this country.

However, 18 months down the line I find that my colleagues have successfully passed the MRCP or FRCS and are now either Specialist Registrars or at least eligible to apply for such a post. However, due to college requirements (Royal College of Psychiatrists, 1996) I have only just been deemed eligible to sit the Part I, which I did in October 1996. I find myself faced with the prospect of working as a SHO for 2 years more, or one at the very least if the College decides to accept my overseas training. Given the fact that present Home Office regulations allow four years' permit free training, the best case scenario for me at the end of that period would be that I would have passed the MRCPsych II. On the other hand my colleagues may have been able to complete SpR training and be eligible for a CCST in their speciality.

I propose that overseas graduates be given the choice of sitting the Part I in the first 6 months in

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this country and the Part II in the next 6 months, contingent on their overseas training being recognised by the College. This option may not necessarily be exercised by all trainees but nonetheless needs to be there for those who think themselves ready to sit the examination.

ROYAL COLLEGE OF PSYCHIATRISTS (1996) *General Information and Regulations for the MRCPsych Examinations*. London: RCPsych.

ZUBIN BHAGWAGER, *SHO, Old Age Psychiatry, Fulbrook Centre, Churchill Hospital, Old Road, Oxford OX3 7JU*

Predicting attendance at child and adolescent psychiatry clinics

Sir: Not all child psychiatry services have high non-attendance rates and I would suggest that the experience of Potter & Darwish (*Psychiatric Bulletin*, December 1996, **20**, 717–718) is unusual. Our service has an unnotified non-attendance rate of 13%. This compares favourably with our local paediatric services, and particularly community paediatric services. There is nothing unusual about our services. We are the main child psychiatry provider for a population of about 330 000, have a multidisciplinary clinical staff (excluding trainees) of 11 whole time equivalents and contracts to provide over 5000 appointments per annum. Steadily rising referral rates (more than 1100 new referrals in 1995/6) have caused a waiting list for non-urgent cases of 3 to 6 months.

How have we achieved low non-attendance rates?

Staff attitude: We regard an unnotified non-attendance as a waste of NHS resources and a disservice to other patients. This view is held by all clinical and administrative staff.

First appointments: All patients have to opt in to their first appointment, i.e. they are given an appointment with a date and time and named clinician but asked to confirm attendance within ten days of receiving notification. Failure to confirm automatically leads to the appointment being vacated and offered to another patient. Our patients appreciate this good management of NHS resources.

Follow-up appointments: All follow-up appointments are booked by the clinician with the family for their mutual convenience. This personal touch probably ensures the patient's realisation that the clinician's time is valuable. Patients who subsequently fail to notify non-attendance at a follow-up appointment are not sent a further appointment, but are sent a letter asking them to contact the clinic to request a further appointment.

Clinician feedback: As part of our internal contract monitoring we provide all clinicians with quarterly feedback on their own clinical activity. This includes numbers of new and follow-up appointments completed, non-attendance rates and individual clinical caseload data. Clinicians are thus aware of their own performance, and of the performance of others.

Purchaser expectations: Our purchasers do not fund patients who do not attend, either by cancellation or by unnotified non-attendance.

Meeting patient expectations: Our contracts specify that referrals have to be made via a GP or paediatrician. This has enabled us to build up a good relationship with a relatively stable group of referers who select and prepare appropriate patients for referral. It is also our impression that patients' cooperation is increased by assessment and treatment procedures which are non-blaming, easy to understand and brief.

K. WEIR, *Clinical Director, Child, Adolescent and Family Consultation Service, East Suffolk Local Health Services NHS Trust, 23 Henley Road, Ipswich IP1 3TF*

Job-sharing

Sir: Part-time training including job-sharing is topical in the *Psychiatric Bulletin* (Abas & Ramsay, **20**, 433; Cremona, **20**, 627–624; West & Taylor, **20**, 685–686). Having viewed the job-share policies of several Trusts in Greater Manchester, a number of pitfalls are evident, especially for training.

It is difficult in a job-share, especially at senior house officer (SHO) level, to fulfil the objective of sharing the responsibilities of a full-time post. Firstly, if each SHO works 2.5 days a week of which one day is a training course, the pair are only on the wards for three days altogether, compared to the four of a full-time employee. In addition, both partners may need to attend ward rounds or case conferences at the same time, further undermining time for clinical work.

Although all policies stated that job-sharers have the same access to training as full-timers, only one stated explicitly that double funding would be available for both job-sharers to attend the same course. Attendance at courses needs to be guaranteed for training.

During SHO training, trainees develop different clinical interests and not all will wish to do the same jobs on any rotation. If job-share SHOs are to have the same training opportunities as full timers (a College requirement), they need to have the flexibility to split from their job-share partner to experience different specialities within psychiatry. One policy stated: "Posts filled on a . . . fixed term basis will only be agreed for a job

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