

This can lead to either dangerous reductions in doses or unnecessarily prolonged periods of treatment. Finally, there is the process of developing a psychotherapeutic relationship with a very vulnerable, chronically mentally ill patient. If the patient is being seen once or twice by a different doctor every six months it is virtually impossible for such a relationship to exist. The discussion will be symptom-orientated and it will be very difficult to get beyond this. In the Camberwell Study (Wing, 1982), when relatives were asked their opinions about junior doctors managing chronic patients, they pointed out that rotating doctors were poorly positioned to notice warning signals of potential relapses, tended to ask routine questions and often did not know other staff involved in the community service.

In conclusion, there appears to be somewhat of a conflict between the long-term training requirements of junior doctors and the immediate needs of the chronically mentally ill today. It is obviously important that junior psychiatrists have experience in the management of chronic patients so that they can develop skills in the prevention of relapse. However, this training needs to be organised in such a way that it does not mean that one group of patients are continually looked after by a doctor who changes every six months. Various compromises between the needs of patients and needs of training are possible. One would be ensuring that all chronic patients are jointly managed by junior doctors and permanent staff. Another would be allocating a different group of chronic patients to the care of the junior doctor every six months and taking them back at the end of that attachment. Whatever the solution, the issue does merit thinking about, researching into and emphasises the key importance of adequate supervision.

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Complaints and allegations – a junior doctor perspective

DEAR SIRS

According to a major insurer, the frequency of malpractice claims in the USA has risen from 10.5 claims per 100 physicians in 1980 to 17.8 claims per 100 in 1986 (St Paul Fire and Marine Insurance Company, 1986). In the UK in addition to an increase in litigation there has also been an increase in the number

of complaints that has reached health authorities within the NHS.

The 'Malpractice Stress Disorder' has been described in the USA (Reading, 1986); it refers to the emotional and behavioural responses of those being sued. Doctors experience allegations as a direct assault on their sense of self. As a result of litigation physicians have experienced some disruption in relation to their role and to their interaction with others (Charles *et al*, 1988). Charles *et al* (1984) found one group showed symptoms of clinical depression including suicidal thoughts while another had overwhelming anger with difficulties in making decisions and a general feeling of dissatisfaction. In one case a doctor committed suicide as a result of litigation (Foulkes, 1987).

It seems that the content and circumstances of allegations have little influence on the nature of the reaction and one study found no significant differences in symptoms between physicians who won and those who lost their trial (Charles *et al*, 1985).

To my knowledge no similar research has been carried out in the UK. My personal observations of colleagues troubled by complaint procedures are that their self-esteem is reduced and they show irritability, anxiety and low mood. The news reaches other departments, hospitals and even other districts; rumour spreads and the colleague is pitied. This lowers self-esteem further. While the matter remains unresolved the doctor has to perform as if nothing has happened. When work performance suffers this in turn lowers self-confidence.

As the junior doctor wants to sit a postgraduate exam the investigation procedures present a burden that inevitably have a negative effect on performance. A failure in Membership exams in such situations has a much more devastating effect than it would have under normal circumstances.

I feel that the investigating body has a responsibility and obligation towards the victim of allegations for as long as investigations proceed which should result in concrete help. I would propose that, as soon as an investigation is initiated, a counsellor is identified who will accompany the doctor while these procedures are ongoing. I would hope that this support will enable the colleague to talk freely and ventilate his or her feelings and have a positive effect on self-esteem and self-confidence.

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Psychiatry in the private sector

DEAR SIRs

Saeed Islam's letter (*Psychiatric Bulletin*, June 1990, **14**, 370) on psychiatry in the private sector cannot be allowed to pass unchallenged as it raises important issues in the context of the current political climate. The letter purports to be a brief research report demonstrating that "the Priory Hospital . . . is prepared and able to meet the needs of a representative sample of psychiatric patients". It does no such thing, but is in fact a brief demonstration of the disingenuous art of false inference.

The study attempts to evaluate the clinical activity of the Priory Hospital (private) and the Charing Cross Hospital (NHS) by comparing crude ICD-9 diagnoses of patients admitted as psychiatric emergencies. It ignores the fact that the objectives of these two institutions are completely different and that they serve demographically dissimilar populations. It compounds this error by implying that the activity of a professorial department in a large London teaching hospital is similar to the activity of NHS psychiatric units generally. It gives no information as to how patients were "surveyed" or sampled, whether retrospectively or prospectively, how emergency was defined or how, when and by whom diagnosis was made. There are no data on secondary diagnoses, chronicity or severity of illness or on demographic characteristics of the two populations. Even if this information were available, admission data are widely recognised to be misleading in service evaluation, particularly in the absence of supplementary data such as length of stay.

The accompanying table is strange: N = 53 for the Priory Hospital but there is no figure given for the Charing Cross Hospital. Percentages for the Priory are lent an air of spurious accuracy by being taken to the first decimal place, but when more closely examined do not correspond in any way to whole numbers of patients. In contrast the figures for the Charing Cross are rounded to a whole percentage point. The letter provides no valid evidence to support its conclusions which are firmly stated as above.

The publication of this letter in the *Psychiatric Bulletin* will be taken to support those who within central government and NHS management are attempting to dismantle comprehensive integrated district psychiatric services and replace them with a quasi commercial service on the disastrous US model. Patient populations in private psychiatry differ greatly from those seen by NHS services, a reason frequently given by psychiatrists for working privately.

Private psychiatry has usually recognised itself to be "complementary" and marginal to the NHS, and in fact is irrelevant to the needs of the largest and most vulnerable group of psychiatric patients.

I trust that in future material such as Dr Islam's letter will be clearly marked "advertisement feature", allowing it to be scrutinised by the Advertising Standards Authority, by whose criteria it will undoubtedly be found wanting.

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DEAR SIRs

Dr Islam (*Psychiatric Bulletin*, June 1990, **14**, 370–371) makes a feeble attempt to compare favourably the emergency services provided by a private (Priory) Hospital with that of a NHS (Charing) Hospital only on the basis that the diagnostic mix of 53 patients admitted to Priory Hospital was not significantly different from that of an unspecified number of patients admitted to Charing Cross Hospital.

He does not make any attempt to consider the other more important variables like the outcome of these admissions and percentages of patients who are not offered admission on the basis of their inability to pay. There is little in his article which makes me reconsider my opinion that the "private sector caters largely for affluent, neurotic individuals . . ." I too hope that Dr Islam will be able to conduct a more meaningful study which I am sure will confirm the common belief among his fellow psychiatrists about the private sector.

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DEAR SIRs

I would like to respond to Dr Rob Poole's criticisms by pointing out that these would have been appropriate if I had assumed that my "brief research report" was a scientific paper.

In fact, I wrote a letter to the *Psychiatric Bulletin*, (June 1990, **14**, 370) providing the readers with my clinical observations regarding the similarities between the diagnostic groups of the patients seen at