Psychiatric Bulletin (1993), **17**, 558–566

Correspondence

Exclusion of psychiatric cover in private medical insurance

DEAR SIRS

Exclusion of psychiatric cover in private medical insurance is a factor of significant concern to psychiatrists, both in private and in NHS practice. It is cynical to play on the belief of Mr Average that he is immune from psychiatric illness and would regard it as an insult to see a psychiatrist. In general, insurance companies guilty of this practice have not been persuaded by arguments – ethical or commercial. Regrettable as this is, the companies involved, however, occupy a very small percentage of the insurance market. Policies that do cover psychiatry competently account for 70% or more of the insured population – but as medical insurance at one time covered 100% of the insured population, it is a trend that should be fought energetically.

Like many psychiatrists I am a member of the Hospital Consultants and Specialists Association (HCSA) and have always regarded that body with esteem as a vigorous defender of the profession. It was, therefore, with surprise that I saw an advertisement in their journal for Sun Alliance Insurance – a company at the bottom of the list for supporting psychiatry. Pointing this out to the Chief Executive of HCSA produced a flurry of interest, followed by lame excuses, and finishing with a letter from Sun Alliance Health, explaining why they did not cover psychiatry. Their Development Manager offers a number of reasons:

(a) the difficulty of defining mental disorders can lead to unjustifiable treatment
(b) many such disorders are chronic and likely to recur
(c) there would be a large premium increase
(d) there is lack of demand
(e) where there is demand, it would be likely from those who know they are predisposed
(f) they may not declare such predisposition which leads to fraudulent claims
(g) such people will display a lack of enthusiasm or effort to return to a normal lifestyle.

If psychiatrists are concerned about such issues, there may be mileage in seeking to educate companies such as Sun Alliance. It may also be that psychiatrists should re-consider their relationship with the HCSA.

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Too much doom and gloom

DEAR SIRS

I read with interest the letter 'Publish or Perish?' by Jose Ferran (*Psychiatric Bulletin*, June 1993, **17**, 374). Dr Ferran feels that many trainees would prefer to put off any research until "after obtaining the membership of the College". As a trainee it is very easy to slip into a mode of behaviour commensurate with there being little more to psychiatry than passing exams, but this is a harmful throwback from medical school days and should be actively combated. Although it is beyond dispute that "passing the exams is a priority" for trainees I would argue that it is also right for research to be viewed as such.

Research is indeed "perceived by many junior doctors ... as an onerous prerequisite for promotion" and nothing more. This negative attitude has been perpetuated by the recent discussion concerning the "publish or perish" philosophy which appears to apply to those wishing to follow a career in psychiatry (Katona & Robertson, 1993; Lewis, 1991). The discussion has been rather one-sided, and clouded by the atmosphere of doom and gloom alluded to by Dr Ferran.

Being involved in research as well as clinical work is often enjoyable, refreshing and certainly educational. In reading around a topic prior to embarking on a specific project many facts relevant to training and exams are encountered. If success arrives in the form of publication this is obviously very satisfying and tends to lead to self-perpetuation of the process, but it should not be the "be all and end all". There is a risk of disappointment and consequent cessation of efforts if publication is viewed as so essential. A healthier and more positive attitude for the psychiatric establishment than "publish or perish" would be something closer to the sporting cliché "it is not the winning but the taking part that counts". Publication in a journal may be seen as a form of quality control for research, but the number of such articles should *not* be the only thing on the minds of prospective employers when reading the "research" section of an applicant's CV. Attempts to explore areas of interest by the trainee in his or her own research, if well planned and carried out and even if not yet published, should count alongside actual publications and could be discussed at interview.

Trainees often need strong incentives to begin research work, despite its inherent value for their own interest and training, and the need to publish in order to progress is probably effective in this regard.

It is important, however, to promote the carrying out of research by trainees in a more positive way; by reminders of the worthwhile aspects of it other than the possible publication at the end. This might even have some beneficial effects on the final product.

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The Mental Health Act and people with mild learning disabilities

DEAR SIRS

The paper by David James (*Psychiatric Bulletin*, June 1993, **17**, 357–358) highlighted the difficulties faced when using the Mental Health Act for people with severe learning disabilities. These difficulties also apply to people with milder learning disabilities as highlighted by the following case.

Mrs N. G., aged 74, had mild learning disabilities and chronic schizophrenia. Concern had been present for months regarding the conditions in which she lived. She had refused access to professionals but, following environmental health concerns, a successful visit revealed her living in squalor. She was incontinent of faeces and urine which were passed through a hole in her mattress on to the floorboards. Faeces were smeared around the house. Psychotic symptoms were not evident but, in view of her physical condition, further assessment of her mental state was indicated. Informal admission was not agreed to, thus Section 2 of the Mental Health Act was implemented on the grounds of mental disorder that was placing her life at risk because of lack of self care. It was not felt appropriate to use the mental impairment category of the Act although it was questioned whether her behaviour could be construed as 'seriously irresponsible' and as a result of her learning disability.

On admission to hospital no evidence of psychosis was revealed and she had insight into her situation. She was transferred to respite care.

This case confirms a number of the points highlighted by James but illustrates other difficulties faced by implementation of the Mental Health Act for people with mild learning disability. It may be argued that the condition the patient was found in was not the result of her mental illness but lack of understanding resulting from her mild learning disability. Had her rights been abused by applying the Mental Health Act? Certainly her physical well-being was at risk and, as the psychiatrist involved in her care, I believe her life would have been in danger if she had remained in her home. A detailed assessment of her mental state was indicated to exclude an acute episode of a previously diagnosed schizophrenia.

It is to be hoped that further audit of the use of the Mental Health Act will assist in the management of these difficult cases but, as James commented, liberalism can lead to reluctance to use the Act which, apart from robbing a vulnerable group of people of proper legal safeguards, may also rob them of access to the professional help they need.

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Multidisciplinary approach in psychiatry

DEAR SIRS

I read with interest the article by Green (*Psychiatric Bulletin*, June 1993, **17**, 359–361) on the functioning of multidisciplinary teams and the problems of working between members from different orientations.

The power structure of psychiatry has undergone a transformation. This change may be a result of change in professional practice, or perhaps, in some sub-specialities, role diffusion or role confusion within the multidisciplinary team (Arya, 1993).

Green commented on the importance of boundaries within the team. In some areas of practice, as when the mainstay of treatment is psychopharmacological, the boundaries are relatively clear, but for treatments which do not require a pharmacological approach (e.g. managing a child with temper tantrums), we tend to accept the musical (revolving) chair game to elect a non-medical leader. I would suggest that treatment prescribed on that day is influenced by the chair.

We need to define the boundaries of our speciality clearly and accept that there may be ailments which came under the remit of psychiatric practice in the past, but are now best catered for by other disciplines with psychiatrists providing specialist advice if requested. Clarification of such boundaries will refine our management.

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