emotionally assaulted by a senior house officer colleague, a career obstetrician. I was frightened and sickened, not only by the action of a man purporting to care for women but also by the attitude of senior colleagues. Two senior registrars advised me not to report the matter to the consultants, who would never believe me, let alone support me. The Medical Defence Union and BMA were factual in their caring; my choice was to pursue the matter to my own distress over many months without guarantee of any outcome or to bite my tongue. In a troubled time I let the matter rest. Now the anger remains, and the shame, that a man such as this will rise through a career structure to deal with women.

This problem must be urgently recognised. It is recognised in industry, where mechanisms for identifying and dealing with such issues are increasingly common. In our caring profession there should be a formalised system whereby the problem can be identified and any members of staff who find themselves in this position know who to turn to to resolve the issue confidentially and without fear of reprisals in their future career. Men such as this may need help. They certainly should be confronted with the implications of their behaviour to women, be they patients or colleagues. The women need to be listened to and supported. Neither of these things happened in my case. Unfortunately, I believe I am not alone.

1 Unprofessional behaviour. *BMJ* 1992;305:962. (17 October.)

Psychiatrists in the new NHS

EDITOR,—Richard Thomas's letter provides a welcome opportunity to discuss the potential impact of general practitioner fundholding on the future development of mental health services.¹ He predicts fewer psychiatric referrals, leading to psychiatrist redundancies. We believe that he has fallen into the trap of extrapolating from clinical trials rather than the audit of real services, and failing to understand the role of the psychiatrist.

It is important to remember that 90-95% of mental disorders are managed entirely by the general practitioner, with only 5-10% being referred to specialist psychiatric services. The common thread running through all the studies of why patients are referred to psychiatrists is the failure to respond to the treatment from the family doctor.² They are not being referred for simple counselling or support.

The silent growth of collaboration between general practitioners and psychiatrists over the past two decades has been impressive.^{3,4} While a variety of different models of working have developed nationally, these remain patchily distributed. The impact of these developments on inpatient and outpatient services has been evaluated.^{5,6} Most studies report that patients and general practitioners are highly satisfied with these services, the role of the psychiatrist often extending to giving advice to the general practitioner about patients who will never be referred to the psychiatric service.^{3,6} While the numbers of psychiatrists working in primary care settings is known (a fifth of consultants in England and Wales, and over half the consultants in Scotland⁷), little is known about non-psychiatrist professionals.

There have been too few studies of the effectiveness of different workers in primary care settings to support definitive conclusions. What needs to be borne in mind, however, is the gap between clinical trials and clinical practice. For example, in the Edinburgh randomised trial of care for depressed patients in primary care cited by Thomas, the psychiatrist's role was restricted solely to prescribing the trial antidepressant—the protocol prohibited the use of any of his psychiatric

skills (psychodynamic or cognitive-behavioural psychotherapy, counselling, social interventions, or choice of drug).

As we see it, the interrelation between the different mental health professions is crucial to this debate. Community psychiatric nurses, clinical psychologists, and other members of the multi-disciplinary team are not totally independent of each other. In practice they are backed up by psychiatrists who, in our opinion, should lead the multidisciplinary team. This role reflects, firstly, their medicolegal responsibilities and, secondly, the psychiatrists' particular contribution, a biopsychosocial approach to mental health problems.

In reality general practitioners and psychiatrists already collaborate effectively at local^{1,4} and national levels. The joint colleges' public education exercise, the "Defeat Depression Campaign," and the forthcoming jointly published book, *Psychiatry and General Practice*, are two examples.

What is to be welcomed is a growing range and variety of help for people with mental health problems. But it has to be recognised that these are not in competition with psychiatry, but are additional to the core and unchanged role of the psychiatrist.

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1 Thomas R. Psychiatrists in the new NHS. *BMJ* 1992;305:834-5. (3 October.)

2 Goldberg D, Huxley P. *Mental illness in the community*. London: Tavistock, 1980.

3 Strathdee G, Williams P. A survey of psychiatrists in primary care. *J R Coll Gen Pract* 1984;34:615.

4 Pullen I, Yellowlees A. Scottish psychiatrists in primary health-care settings. *Br J Psychiatry* 1988;153:663.

5 Williams P, Balestrieri M. Psychiatrist clinics in general practice—do they reduce admissions? *Br J Psychiatry* 1989;154:67.

6 Tyrer P, Seivewright N, Wollerton S. General practice psychiatric clinics: impact on psychiatric services. *Br J Psychiatry* 1984; 145:15.

Funding of hospital training grade posts

EDITOR,—The NHS Management Executive has agreed that from April 1993 50% of basic salary costs and 100% of out of hours pay of full time training posts are to be included in contract prices, the remainder being met from a regionally held budget.¹

This is excellent news for districts that purchase services from teaching hospitals and regional centres as the higher costs attributable to the large number of training posts result in higher prices for a given service. In a year or so this would have meant less care being available to the residents of these districts when the district's financial allocation becomes based solely on the size and morbidity of the resident population.

Now that the principle of regarding some aspects of medical and dental salaries as a regionwide overhead has been established, the next anomaly that should be treated in this way is the cost of higher distinction awards. As higher awards are predominantly based on research and on regional, national, and international activity the number of award holders is inevitably much higher in teaching hospitals, thus raising the cost of services to districts using these hospitals. It would be fairer to recognise that the activities that lead to higher awards are an important contribution to the NHS as a whole rather than to the local district, and to treat the additional cost of higher awards as a regional responsibility.

This would certainly be preferable to the alternative of establishing a complex bureaucratic system

of recharging regional health authorities, the Department of Health, royal colleges, etc for the time individual consultants spend away from their hospital. At the end of the day these costs would be met by the NHS either by top slicing at department or regional level or by increased allocations for postgraduate medical and dental education.

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1 NHS Management Executive. *Funding of hospital medical and dental training grade posts*. London: Department of Health, 1992. (EL/92/63.)

Medical audit advisory groups and confidentiality

EDITOR,—John Russell creates a false impression in his letter about reaccreditation in general practice.¹ In an otherwise accurate account of the way in which general practice is currently monitored he states that medical audit advisory groups report back to their family health service authorities after visiting practices. The medical audit advisory group is indeed accountable and is required to submit regular reports to the authority. Information in these reports is, however, anonymised so that individual doctors and patients cannot be identified. This process was clearly outlined in the original health circular about the establishment of medical audit advisory groups.²

In our experience of working with medical audit advisory groups in the Northern region, confidentiality seems to be the issue causing most concern to general practitioners. To secure doctors' participation in medical audit, trust needs to be fostered. If advisory groups are perceived as being "audit police" this is unlikely to happen. We hope that this letter helps remedy any such misconceptions.

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1 Russell J. Reaccrediting general practice. *BMJ* 1992;305:835. (3 October.)

2 Department of Health. *Working for patients. Medical audit in the family practitioner services*. London: HMSO, 1990.

Surgical correction of nearsightedness

EDITOR,—In their review of the surgical correction of myopia, Samir J Bechara and colleagues state that surgical methods to treat refractive errors were first proposed a century ago.¹ In their table they indicate that Fukala (1890) contributed the first development in such techniques with his removal of the lens in cases of high myopia. This overlooks Baron de Wenzel, who was working in Paris before 1775 and, at the suggestion of the abbé Desmonceaux, treated young people with high myopia in the same way.² We do not know what results they had, but in 1786 the abbé continued to be strongly in favour of this procedure.

Earlier still, Joseph Higgs of Birmingham in 1745 and Albrecht von Haller in 1763 suggested couching for this condition, but neither of them seems to have put this idea into practice.

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1 Bechara SJ, Thompson KP, Waring GO III. Surgical correction of nearsightedness. *BMJ* 1992;305:813-7. (3 October.)

2 Wyman AL. Baron de Wenzel, oculist to King George III: his impact on British ophthalmologists. *Med Hist* 1991;35:78-88.