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Protection from Occupational Hazards

SIR,—As a lawyer I was most interested in your Legal Correspondent's article "Hepatitis Contracted in the Course of Employment" (4 December, p. 632).

As he so rightly points out, the "fault-liability" concept of the law of negligence renders it ill equipped to deal with the situation where a plaintiff has contracted hepatitis in the course of his employment. As to reform, amendment of existing legislation is, of course, desirable, but in all but

the most exceptional circumstances this is an unbelievably slow process.

Consequently, it is to their professional organizations that doctors should look for protection in this field, through country-wide agreements with their employers. Suffice it to say that even the least militant of the trade unions do an admirable job in protecting the interests of their members in very similar circumstances.—I am, etc.,

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patients as a little trouble spent in prophylaxis can avert a major medical emergency.—We are, etc.,

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Education of Diabetic Patients

SIR,—Many diabetics admitted to hospital in severe ketoacidosis have misguidedly reduced or omitted their insulin in the face of intercurrent illness, or have failed to increase their insulin not realizing there is an increased demand resulting from illness, particularly infection. In such circumstances death from severe ketoacidosis can occur, and this is preventable if the diabetic patient is taught how to manage his diabetes properly in these circumstances.

To try to prevent such disasters, we should like to suggest the following guidelines for management of diabetes in the presence of intercurrent illness.

Patients should be advised that their normal carbohydrate allowance be taken as fluids, which can frequently be tolerated even if solid carbohydrate cannot. One tablespoonful of Ribena, four tablespoonsful of Lucozade, or two teaspoonsful of sugar dissolved in water flavoured with diabetic squash, are each equivalent to 10 g carbohydrate and can be used in place of solids.

The urine must be tested twice daily and if 1-2% glycosuria develops in the presence of infection the insulin should be increased. For adult diabetics on twice daily soluble insulin an increase of about 8 units on each

dose until the urine shows less than 1% glucose, is usually adequate. If this does not rapidly restore control an extra dose of about 8 units of soluble insulin may be given before the midday meal, as long as the urine at that time shows 1-2% glucose.

For diabetics on a single injection of soluble plus a long acting insulin, if the urine before the injection and before the evening meal shows 1-2% glucose, the soluble insulin should be increased by about 8 units in the morning, and an additional dose of about 8 units of soluble insulin should be added before the evening meal. These doses may need further daily increases until there is less than 1% glycosuria.

Increasing the dose of a daily injection of lente or isophane insulin is often not very effective in overcoming a rapid increase in insulin requirements, and if control is not rapidly restored by so doing it is wise to switch temporarily to twice daily soluble insulin.

Finally, if diabetes is not rapidly controlled at home in the presence of intercurrent infection and particularly if there is continued vomiting, the patient should be admitted to hospital. Hospital doctors should always be ready to admit such

Future of British Psychiatrists

SIR,—You are to be congratulated on your attempted apologia for the Royal College of Psychiatrists' fracas in your leading article "Future of British Psychiatrists" (27 November, p. 509). It was most unconvincing, but a brave attempt at a hopeless task.

One feels rather like the little boy who noticed that the Emperor wasn't wearing any clothes in pointing out the realities of the situation, but there has been so much muddled thinking on this subject in recent months that some clarity is called for. There is simply no excuse for the frantic rush with which the new Membership exams have been set up. Such unseemly haste was in response to no perceptible demand from college members or future members, and had little rational basis. To suggest, as your leading article did, that this was necessary "to show junior psychiatrists in good time what would be expected of them" is the very distillate of educational double-think.

Let us be quite clear about this. The M.R.C.Psych. exam, as presently constituted, has no claim to educational respectability, and will of necessity be of very questionable validity and reliability. It was drawn up in isolation and without proper consultation of competent experts in the field of medical educational assessment. Even previous R.M.P.A. considerations of the subject had been disregarded, let alone

the very cogent advice of the Royal Commission. The college has not bothered to take the time to draw up any recognizable goals or objectives, and there is still no readily available source of competent training in psychiatry in preparation for the future. The design of any educational testing procedures, especially postgraduate examinations of major career significance, must, logically, begin with a definition of the professional roles and behaviours involved and a description of criteria for judging competency within these roles.

Such an examination, drawn up hurriedly by a group of men who, no matter how distinguished they may be clinically and professionally, have evinced no special competence in the difficult and critical skills of educational assessment design, cannot claim to have anything to do with the maintenance of standards. As no standards have been defined, no examination can maintain them.

A strange confusion is very common in this area. It is usually assumed that "standards" are "maintained" if you set a large and complex, difficult and expensive examination, and then fail a lot of chaps at the end of it. This is directly analogous to setting up an involved and very expensive system of physical examination for patients, and arguing that you are improving the standards of community health by ensuring that a very large proportion of the public fail to be passed as fit.

This is really displacement activity of a

pretty high order. Whatever the administrative or financial advantages of such an arrangement it has nothing much to do with valid assessment. It has little to do with any standards, except its own arbitrary and artificial ones. Indeed, by encouraging a concentration on the clinically irrelevant (because it is easier to examine) it may even unfavourably influence actual clinical standards.

Much of the anguish shown by the psychiatrists in training and the profession in general (and shared by other distinguished journals) has been because it had been hoped, in vain, that the wise and honourable men in charge of the college would have had the foresight and vision to have constructed a genuine, valid examination system, based on a proper system of training; a system appropriate to the latter half of the 20th century, rather than that which crystallized in the Chinese civil service during the late T'ang period.

Professional education for the future cannot afford the luxury of allowing these matters to be decided on the basis of amateur enthusiasm rather than professional competence. Let us hope that the college will have the courage and humility to admit that they were mistaken, and to start again in earnest. If the college cannot raise its own standards as examiner, it will never benefit the standards of psychiatric practice.—I am, etc.,

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Hospital Advisory Service

SIR,—It is with some trepidation that I venture to join in the correspondence about the Hospital Advisory Service because it may be thought that I am speaking for one, or both, of the boards of which I happen to be the chairman. To emphasize that this is not so I am writing from my private, though temporary, address.

My excuse for this letter is that I have had considerable experience of advisory services in a large international group of industrial companies and may, as a result, be able to say something useful. I do not hold the opinion that a management practice which has been proved a success in the industrial world can always be transferred, with equal success, to the National Health Service; each one has to be considered and judged on its merits. But I am a strong advocate of advisory services as a whole because they enable each individual unit to learn from the experience of all the others. The claim, which was made in the group of companies where I had this experience, was that we were able to produce, in total, a better result than the sum of the individual parts; that is to say, the majority of the individual companies gave a better performance, thanks to the help of the advisory services, than they would have done on their own.

This happy result was not achieved in a day. It was built up over a number of years by frequent personal contacts and, eventually, the appreciation by the people in the field that the visits were an opportunity for an objective self-examination and also an opportunity to contribute to the common pool of knowledge and experience. The members of the advisory services were regarded as part of "us," which did not mean

that we did not exercise our rights to grouse about them (where is there an organization which does not criticize those who come from the higher authority?) but if an outsider criticized them he was criticizing "us."

It is not easy to be a good adviser and anyone taking on the task, no matter how expert he is in his own special field, has to acquire an additional skill with which he can gain the confidence of the people whom he seeks to advise. It is, I suppose, a matter of mutual trust and I beg leave to doubt if it can be established by teams who are doing it for no more than a year. I also doubt if it is really wise to establish an advisory service of any kind outside the Department of Health. The Hospital Advisory Service came into being as the Secretary of State's "eyes and ears" after the discovery that all was not well in some psychiatric hospitals. I believe that it was a sensible decision at that time and in the circumstances of the moment, but I suggest that the time has come to bring it into the Department of Health with the task of advising all levels of the National Health Service from the Secretary of State downwards.

I believe that the Hospital Advisory Service has already done useful work but that its full value depends on its ability to get itself accepted as part of "us" and its visits regarded as opportunities to "give and take." If it does this it will, I hope, be the forerunner of other advisory services in the Department of Health with expert knowledge individually, added to experience of what is going on all over Britain, and, for that matter, elsewhere in the world. If I may be permitted to add one final word of advice—no advisory service will ever establish an atmosphere of mutual trust if

it insists on including in its reports, and in the discussions related to them, adverse criticism of individuals. There are other ways of dealing with such matters. I am a strong believer in bringing all staff into the picture but not to the extent of comments on individuals.—I am, etc.,

DESMOND BONHAM CARTER

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SIR,—A little while ago I gave a "Personal View" (6 November, p. 359) of a visit by a Hospital Advisory Service (H.A.S.) team to a hospital where I was working. I said I was disappointed with them because they seemed to come as political missionaries. Dr. A. A. Baker, the director of the H.A.S., was evidently irritated by this and wrote to you (20 November, p. 487), maintaining my article contained many errors, an extraordinary assertion since he never came to the hospital, whereas I was there for the first two weeks of the team's visit. In fact, everything I wrote, however lightly, had a basis in what I or my colleagues experienced. As this appears to be the first occasion on which anyone has scrutinized the H.A.S., perhaps you will allow me to elaborate a little on the matters of general interest.

Dr. Baker writes in a Department of Health publication "the Service is independent and is not committed to any particular policy on behalf of Department or Board."¹ The reality, however, seems rather different. In a report on one hospital, under hospital social work services, we read (para 66) "Since the appointment of a principal social worker in September 1969, the department has gradually been built up so that now there are five fulltime and two part-time social workers. . . ." and then (para 67) "The rationale for developing a social work department when policy was moving towards comprehensive local authority social services is not clear . . . in future the local authority social services department will command the resources for the development of a range of community facilities for the mentally ill." As I originally reported, our head social worker was disappointed that the team member who interviewed her did not want to know what her problems were, but instead told her and her colleagues to go and join the local authority department.

Since Seeborn,² the local authority social work service has been in some disarray, here as elsewhere in the country, and mental health care has diminished. If Dr. Baker's advice were followed, the net effect would be to give psychiatric patients even less social work help than they are getting now. I think it is evident that this advice stems not from the realities of the local situations and what might therefore actually benefit the patients, but from a central policy based on quite different considerations and to some extent on dogma: "hospital social work departments are bad."

By coming with these fixed beliefs the H.A.S. is missing a great opportunity of collecting facts about the functions of social workers in hospital or about the functions of leadership in hospital organization. For instance, I wish they would listen more and study local circumstances more, and draw some knowledge from operational research. I wish they could sometimes be less superficial. To answer a nursing staff's complaint that the hospital is understaffed simply by saying that the overall patient/nurse ratio