

complaint could lie against a doctor merely on the ground that he had complied with an order of a court. Any attempt by the GMC to proceed against a doctor in these circumstances would quickly be thrown out by the courts, on the application of the doctor's medical defence organisation, as an abuse of process.

It is clearly good practice to inform a patient that an order requiring the release of his records has been received, and has to be complied with. Thompson suggests that a psychiatrist might be instructed by 'court officials' not to inform the patient. It is difficult to envisage any situation that is not fanciful in which a court might be minded to direct that an individual should not be informed that an order requiring the release of his medical records had been made. As judicial proceedings and court orders are ordinarily in the public domain, it would obviously be necessary for the court also to direct that references to these matters should be omitted from the public record of the proceedings. While disclaiming any legal expertise, I would doubt that any such powers exist, save in the most exceptional circumstances, such as cases involving issues of national security.

Thompson says that the Civil Evidence Act 1995 calls the process by which psychiatrists are requested to attend court 'being served with a witness summons'. The Civil Evidence Act 1995 does not deal with witness summonses (it is principally concerned with the admissibility of hearsay evidence) and includes no such statement. The article includes a table (Box 1) headed 'Standards expected by courts of an expert witness'. This is an adaptation of recommendations made by the Academy of Medical Royal Colleges in 2005.³ The judiciary have not published any list of qualifications required to be possessed by expert witnesses, medical or other. The heading is accordingly misleading.

- 1 Thompson AE. 'You are instructed to prepare a report . . .' How to make sound decisions about whether to accept or decline medico-legal work. *Psychiatrist* 2011; **35**: 269–72.
- 2 General Medical Council. *Confidentiality*. GMC, 2009.
- 3 Academy of Medical Royal Colleges. *Medical Expert Witnesses: Guidance from the Academy of Medical Royal Colleges*. AMRC, 2005.

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Author's response

Dr Bronks takes issue with a number of matters in my paper and helpfully includes extracts from source materials to orientate the reader to his corrections and clarifications. While bowing to Dr Bronk's superior knowledge of legal detail, I stand by several of my assertions which reflect decisions I have been supported to make in my clinical practice. I suggest that this exchange illustrates that decisions made in medico-legal work are always open to challenge, and psychiatrists should have a low threshold for seeking advice on a case-by-case basis about medico-legal matters.

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Perspective of a foundation year 2 doctor on psychiatry in the foundation programme

As a foundation year 2 (F2) doctor currently rotating through a pilot post in psychiatry in the Northern Deanery, I read 'Improving psychiatry training in the Foundation Programme'¹ with great interest. I am in broad agreement with the authors that psychiatry placement in the foundation programme is of great benefit both to the new doctor in terms of experience and to the profession as a whole, boosting awareness of the specialty and recruitment. However, based on my experience so far in psychiatry I have become aware of several possible detrimental effects of psychiatry as an early foundation placement for F1 doctors.

In their article, Welch *et al* stated that there may be 'difficulties maintaining medical skills' and 'acquiring acute medical competences'. A newly qualified F1 doctor working in a medical or surgical job experiences an extremely steep learning curve as they develop skills in grappling with acute medical problems and basic everyday tasks such as prescribing medications and fluids, phlebotomy, cannulation and traditional ward rounds. Although some of these experiences are common to psychiatry, the role of the foundation doctor in the mental health multidisciplinary team is quite different and unique. Often the mental health multidisciplinary team looks on the foundation doctor for medical advice and management of patients with physical health problems. I perceive two problems with a newly qualified F1 doctor rotating through psychiatry during their first or even second placements. First, the F1 doctor is unlikely to be able to complete the steep learning curve for practical tasks at the beginning of their year, when general hospitals offer more support and are often more lenient as the new doctor develops basic skills. This could leave the F1 doctor with feelings of incompetence and possibly lead to them being viewed so by peers, seniors and ward teams when commencing a medical or surgical job later in their first year. Second, without a good grounding in dealing with common medical problems with supervision from a medical team in a general hospital, the F1 doctor is likely to lack skills and confidence in the management of physical health problems on a psychiatric ward. Therefore the benefit for the mental health multidisciplinary team of having a foundation doctor with some competence in managing physical problems is lost and the doctor may feel out of depth. Doing medical on-call work may help to minimise these effects, but infrequent duties may exacerbate lack of confidence and F1 doctors may feel thrown in at the deep end during out-of-hours work compared with peers working daily in medical jobs. I feel it is the daily work of an F1 doctor on medical or surgical wards that allows for these skills to be developed and consolidated.

Therefore, it is my opinion that F1 doctors should not be rotating through 3- to 4-month psychiatry placements for the first 8 months of their training year, but that a placement would be beneficial for the trainee in the later months once a firm medical foundation is in place. This would allow the trainee to approach their psychiatry placement with more confidence and therefore value the experience more, while not being detrimental to their initial medical training as a whole. However, given that experience in psychiatry is important in terms of recruitment and allowing foundation trainees to experience the specialty as a graduate,² in addition to longer

placements at the end of F1 and through F2, perhaps shorter 1-month tasters as suggested could be considered at any stage in foundation training. This is especially pertinent given that applications for core training are submitted early in the F2 year.

1 Welch J, Bridge C, Firth D, Forrest A. Improving psychiatry training in the Foundation Programme. *Psychiatrist* 2011; **35**: 389–93.

2 Brokington IF, Mumford DB. Recruitment into psychiatry. *Br J Psychiatry* 2002; **180**: 307–12.

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