Family Day Unit present with severe emotional and/or behavioural disorders. This alone would seem to justify the involvement of a (child) psychiatrist in child abuse cases, both for assessment and treatment purposes.

(2) Dr Dunn appears to be unaware of a large body of work by child psychiatrists, social workers and allied child care professionals who have over the years attempted to establish reliable ways of assessing the likelihood of re-abuse (some of it summarised in[1]). To state, as Dr Dunn does, that we do not know what the behaviours are that may lead to rehabilitation, other than "not to abuse their children", shows a somewhat limited understanding: the actual act of abuse is not an isolated phenomenon but only one (though probably the most severe) symptom of inadequate or "dangerous" parenting.

(3) To suggest that the decision to return an abused child to his home "is essentially a moral problem" is worrying: whose morals anyway? Courts in fact request child psychiatrists to provide more objective information[2], not "pseudoscientific" or moralistic statements.

KARL ASEN

Marlborough Family Service
London NW8 0PJ

References

[1] ADCOCK, M. & WHITE, R. (eds) (1985) *Good-Enough Parenting: A Frame-work for Assessment*. Practice Series 12. London: BAAF.

[2] BRITISH AGENCIES FOR ADOPTION AND FOSTERING (1984) *Taking a Stand: Child Psychiatrists in Custody, Access and Disputed Adoption Cases*. Discussion Series 5. London: BAAF.

Psychiatric ward rounds

DEAR SIRS

Dr McBride (*Bulletin*, February 1988) addresses the format and use of ward rounds.

I would propose that, just as there is no single formulation for a patient, there is no ideal ward round which is applicable to all situations.

General psychiatry is very different to some of the sub-specialities. In child psychiatry one ward round a week is adequate; however the presentation of a new case may take up to an hour with various disciplines contributing. On a general ward where there is a rapid through-put I feel two rounds a week are preferable, perhaps with one being a mini-round conducted by the SR.

I feel it is wrong to divorce teaching from the ward round. All the disciplines have much to learn from each other; thus the consultant is not always the teacher, nor the registrar always the pupil. Academic psychiatry is better understood and remembered when learned in a clinical setting. If patients are to be spared the trauma of being interviewed in the round then they should be seen both before (to ascertain mental state) and after (to inform). The cohesiveness of any team will be eroded if any member ignores the team plan; a doctor is more likely to be guilty of this if he fails to assess the patient adequately before or during the round.

The timing of a round will depend on local factors. Although the morning is busy, a round then permits investigations, phone calls and letters to be completed by the end of the day.

There is no 'correct' format for all rounds but Dr McBride's article has prompted many of us to criticise them for the first time.

D. A. FIRTH

Booth Hall Hospital
Blackley, Manchester

The College and South Africa

DEAR SIRS

When Christian Barnard pioneered the first heart transplant, Malcolm Muggeridge, during a televised debate, repeatedly asked "Why South Africa?". It might now be appropriate to ask "Why the Royal College of Psychiatrists?", as the British Psychological Society and the London Colleges of Physicians and Surgeons, among others, have not been similarly prompted to encourage, in effect, an academic boycott of that country. Its value in promoting stabilisation and the over-due abolition of apartheid is debateable, to say the least. According to Professor Simpson (*Bulletin*, April 1988) Fellows continue to make well-funded visits to give presentations "usually irrelevant to our real professional problems". What is the motive behind this posture of the College?

T. L. PILKINGTON

'Old Landings'
Rythergate, Cawood,
Nr Selby, North Yorkshire

Part-time training in psychiatry

DEAR SIRS

Some of my colleagues and I are becoming increasingly concerned about the difficulties experienced by those doctors (usually but not only women with children) who want to train in psychiatry on a part-time

basis. Perhaps interested doctors could contact me, with a view to exploring the problems, and to setting up a job share register.

NANCY DARROCH-VOLOSHANOVICH
Greenwich District Hospital
Vanburgh Hill, Greenwich
London SE10 9HE

Medical insurance fees

DEAR SIRS

Dr Lucas asks for our opinions on defence subscriptions (*Bulletin*, March 1988).

The annual fees are high and increasing alarmingly. Our speciality holds a lesser risk than many; however, differential insurance fees will directly lead to differential incomes as the review body takes them into account.

I feel most "hard pressed junior psychiatrists" are relatively better off than their peers. They earn similar UMT payments although less on call time seems to be spent on the wards than in other acute specialities, and juniors generally seem to progress up the hierarchy more rapidly, so they are rarely left in a junior post paying a maximum subscription.

Possible alternatives to reduce subscriptions to those committed to the NHS are:

(1) pressurising our employers to provide cover for us (as now happens in the armed forces.)

(2) having a basic rate for full-time NHS work with an additional charge to the individual proportional to the income accrued from private practice.

Making us a 'special case' will only serve to alienate us from our colleagues.

D. A. FIRTH
Booth Hall Hospital
Blackley, Manchester

DEAR SIRS

I fully agree with the first part of the letter from Dr R. Lucas (*Bulletin*, March 1988) and disagree with the College's attitude that the increase of the insurance fees is not "within the remit of the College". The Royal College of Psychiatrists should try to negotiate with other insurance companies and obtain competitive rates for insuring its members and those working in psychiatry.

However, the idea of the College putting pressure on the Health Service to pay the insurance cover for psychiatrists in the Health Service is a different matter. If this is done, undoubtedly the insurance cover will have to be paid by individual District Health Authorities, thus giving the managers a lot of power over our conditions of service and they will then, rightly so, demand that the consultants' contracts of employment be held at District level.

B. P. MARAGAKIS
Billinge Hospital
Billinge, near Wigan

DEAR SIRS

In the letter on medical insurance fees (*Bulletin*, March 1988), Dr Lucas argues the case for differential insurance rates according to specialty, believing that psychiatrists would then have to pay less. He says that he is sure that "financially hard pressed junior psychiatrists" would share his view. Does he believe that junior doctors in accident and emergency or general surgery are any less hard pressed financially? How are they to afford the increased fees that would fall upon them?

The NHS pays a junior doctor the same salary whether he or she is in a specialty with a low risk or a high risk of being sued. With a uniform pay structure there is no option but to have uniform defence fees. The same argument applies to consultants. If differential rates were introduced there would be a strong and understandable call for differential pay scales. This would not be in the best interests of the profession.

A more appropriate solution to rapidly increasing defence fees is for the pay review body to continue to take the fees into account when it is making its recommendation and to itemise this separately. This would give a clearer picture of whether medical insurance fees were being fully underwritten and would also give a more accurate figure of the "real" percentage pay increase each year.

Dr Lucas's solution would be divisive and the College should not support it.

C. A. CAMPBELL
Chairman, East Anglian Regional Hospital Junior Staff Committee
Fulbourn Hospital
Cambridge

DEAR SIRS

Dr R. Lucas (*Bulletin*, March 1988) claims that psychiatrists are paying excessively high insurance premiums, quoting a random analysis of 100 medico-legal cases in the West Midlands in which there was not a single psychiatric case. The defence organisations present anecdotal material about the risks involved in psychiatry, but are unwilling to divulge any data about the levels of claims and settlements between specialties.

In the USA litigation is a major problem in all branches of medicine, including psychiatry. Psychiatrists, however, pay lower premiums than most of the major specialties. Their premiums average