the team would act as a catalyst in the development of both existing and new services in the Region and as a means of achieving the co-ordination of this development". I believe we have met those requirements. We have been able to give advice and to encourage Districts in the development of their services. We have given support to those developing services and in particular to their staff. We have had an educational and training role and this will continue in the future. We have also been able to bring together workers in the statutory and non-statutory agencies. I believe this co-ordinating role to be of particular importance. In Wessex Region there is a lot of enthusiasm amongst a wide variety of agencies in developing services for drug misusers. It is vitally important for the optimal functioning of those services that they work closely together. To achieve this is one of the main challenges for the future.

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Conference Report

A Subversive Foray into Private Practice

Sydney Brandon, Professor of Psychiatry, University of Leicester

The Private Sector is responding to Mrs Thatcher's call. Nearly one hundred psychiatrists of all varieties and persuasions each paid £10 to attend a Saturday morning seminar on Private Practice in Psychiatry at the Royal Society of Medicine—I wonder if they applied to their Health Authority for study leave and expenses.

Nine speakers offered succinct statements on 'How to Succeed in Private Practice without risk to your Ethics.' Even so they managed to fit in an elegant buffet with wine and, naturally, served tea before the contented punters departed a little before the 2.30 pm scheduled finish. A good example of how to spend a full and profitable day yet still fulfil your golf commitments.

All the speakers modestly declaimed their impeccable personal pedigrees and shot their immaculate cuffs before casting their pearls before a rather more mature (or older) audience than the organisers had anticipated.

We learnt that severely depressed and suicidal patients can be discharged as good as new after 19 days in hospital and that community care and job satisfaction are more meaningful when dealing with BUPA subscribers than when one is "getting somebody ready to return to some monotonous and repetitive job".

One consultant assured us that what the private practitioner needs to succeed is Availability, Affability and Ability—strictly in that order.

A gamekeeper-turned-poacher advised us on how to use the NHS consultant contract to maximal personal advantage including the subtleties of when to opt to go maximum part time and when to revert, how to hang on to your expenses and so on. Those suffering from impending burn out after their stressful years as asylum (or is it mental health) officers were advised on how to increase their lump sum and maximise their pension before retiring into private practice.

Once you pass on to those Elysian Fields there are, we were assured, no committees but managers whose only wish is to facilitate your every desire in providing patient care and the ultimate in multi-disciplinary (therapeutic staff) teams. They've finally cracked it! In private hospitals the multi-disciplinary team is, for the psychiatrists, 'at your command'. Warmth, comfort, security, convenience, a nicer class of patients and positively luxurious hotel services await the aspiring visiting consultant and the full-timer will be entering a 'smooth and expanding service'.

The growth in private practice in this country has not

been as great as expected in many circles and the 'health care industry' in the USA has experienced recent set-backs.

Private health care has been predominantly surgical care with a focus on acute, short-term interventions though now 13% of non-urgent surgery is dealt with by the private sector. In 1946, two years before the National Health Service began, 100,000 people had private health insurance, now there are five and a quarter million and the numbers are growing.

In this country private psychiatric care has been slow to develop. There were 25 full-time private psychiatrists in 1980 in England and Wales (referred to by American administrators as Britain) and in 1986 there were 60 full timers and 300 psychiatrists with a substantial commitment to private practice. From a handful of private hospitals there are now 23 private psychiatric hospitals with 1,761 beds of which only 182 accommodate chronic patients. In addition most private hospitals will accommodate psychiatric patients who do not require compulsory detention and there are between 40 and 50 Licensed Mental Nursing Homes.

Although ethics and morality were referred to in passing by most speakers the only issue identified was the need to be 'whiter than white' in avoiding the use of NHS resources for private practice.

Altogether it was a well managed and seductive presentation. The flavour of efficient private management was conveyed by the chairman's (Yale and CPC) milli-second pause before confidently declaring "Since there are no questions we can go to lunch."

Why were so many people willing to give up a pleasant Saturday morning to be initiated into the ways of private practice? Were the academics searching for means of increasing their departmental funds, the battle-weary senior consultants seeking a friendly shore after their battering by the successive waves of reorganisation of the NHS and the young seeking an alternative career, or were they all speculating on how to reduce their overdrafts?

There will always be private practice whether the consultant is paid or not. The question is how far should the private sector be extended and for whose benefit?

I believe that the National Health Service should provide humane, comprehensive, basic psychiatric care and that none should be deprived of such care because they are unable to pay for it. We have not yet achieved this state and could never hope to do so without the effective filter systems which we currently operate.

Some patients may not be admitted to the hospital of their choice and may not be able to stay there as long as they or their family would prefer but they should be able to stay as long as is medically necessary. Out-patient care should be available to all who need it as should drugs and other physical treatments.

If we accept these as reasonable aims for the NHS psychiatric service what if any will be the effect of a burgeoning private sector? Nothing I heard at this meeting suggested that private care as presently practised or envisaged would benefit the NHS or the population at large. Is there any evidence of such benefit?

The investment in staff time and hotel services of the private sector could never be replicated in the NHS but is there any evidence of actual or potential harm to the services?

Is there a critical level at which the private sector would operate to the detriment of the NHS? Removing the voice of the articulate consumer, the cost of training doctors, nurses and other professionals, invidious comparisons between the quality of life of both patients and staff in two distinct services and the increasing proportion of non-insurable chronic care falling upon the NHS are all factors which much influence the State service.

The implications for education of a growing private sector have not been worked out. General Practice Vocational Training Schemes now need accountants among their teachers. Should we in the universities be preparing students for the vicissitudes of private medicine, do our manpower planners know what is happening (even apart from private practice), should our rotational schemes involve not only peripheral but private hospitals and should such rotations be compulsory?

We must begin to address these and other questions in the public and professional arena. There must be means of monitoring private practice and a constant appraisal of its effects upon or interaction with the NHS. If there is a demand for private practice can the NHS not benefit from this instead of providing a well-padded launching pad for private consultants and a safety net for those who fail to respond, or pay for, private care.

One private hospital exists solely to provide secure accommodation on a contract basis for those health authorities who have no local facilities. With 49 beds and a charge of about £35,000 per patient per annum is this an economical solution? If an American company can run this at a profit, why can't the NHS?

Do we have to recognise that certain kinds of care such as some or all of secure accommodation, the management of the severely head injured, psychosexual counselling, intensive psychotherapy or long-term social skills training cannot be provided as basic care and have to be contracted out or sought privately?

There are many more questions which need to be answered but how and by whom? Will the Chief Scientist fund the necessary research or must we seek funds from a multinational conglomerate?

If we fail to discuss the issues, define the questions and find the means to seek the answers we may end up by destroying a system which despite its problems has the best potential of any health care system in the world.