Editorial did not acknowledge BMA's work

EDITOR,—I was disappointed by Richard Smith's editorial on the suggested academy of medicine.[1] Neither it nor the accompanying consultation paper directly refers to the fact that the meeting at which Sir Maurice Shock gave the advice that Smith quotes was organised by the chairman of the BMA's council; to the subsequent work carried out by the BMA's staff and working group; or to the (now aborted) efforts by the Conference of Medical Royal Colleges to describe the possible pattern of medical practice at the beginning of the next century.

The editorial contains two serious inaccuracies with reference to the Conference of Medical Royal Colleges: the conference does not have to apply to anyone to change its name, and it has leased space in the Royal Society of Medicine's building, not been "given a home and a secretariat."

Smith also fails to observe that to a considerable extent the proposals in the consultation paper relate to an academy of health rather than of medicine.

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1 Smith R. Does Britain need an academy of medicine? *BMJ* 1996;312:1374-5. (1 June.)

Junior Doctors Committee proposed an academy in 1994

EDITOR,—We were surprised to find a consultation paper on a possible British academy of medicine included in our copy of the *BMJ* at the beginning of June.[1] We recognise the need for such a national academy but are concerned that this brief consultation paper was published by a group separate from and without representatives of the BMA.

The Junior Doctors Committee supports the formation of an academy, having published a discussion paper on the subject in 1994, which was widely circulated within and outside the BMA. The problems with the latest proposals arise from the remaining questions, which, though relevant, are followed in the consultation paper by points of qualification that seem intentionally to restrict debate on the structure or function of an academy. We are particularly concerned that many of the suggested functions are already performed by the BMA and that the proposed academy would become just another talking shop rather than replacing any existing structures. This contradicts an earlier statement in the paper that "the number of bodies speaking on and about medicine in its broadest sense is growing." We would heartily concur with the statement that "the present situation is one of Byzantine complexity." We are also concerned about the proposed structure of the academy, whose members should be "individuals whose expertise and experience irrespective of age is recognised by their peers," since the method of selection is not mentioned.

The Junior Doctors Committee's proposals for an academy of medicine were designed to create a single body regulating the profession, its education, and training, with a central council to replace and extend the current structures and functions of the General Medical Council. We proposed that all the interested parties, including patients, would have representation in the academy as the central focus for debate on all matters relating to British medicine, both practical and ethical. This simplified structure would also subsume the functions of the new Specialist Training Authority. Professional self regulation could be retained while, simultaneously, a credible forum for discussion of relevant issues was created. The academy would neither replace nor dilute any of the duties and responsibilities of the BMA to represent the interests and opinions of the profession itself.

We hope that the consultation paper on a possible British academy of medicine will stimulate a much wider debate about the structure and function of such a body.

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1 Smith R. Does Britain need an academy of medicine? *BMJ* 1996;312:1374-5. (1 June.)

Profession should resist further fragmentation

EDITOR,—Others will no doubt seek to address some of the minor but important inaccuracies in Richard Smith's stimulating editorial on the proposal that an academy of medicine should be set up.[1] I would prefer to exhort the profession to be cautious of erstwhile mathematicians (such as John Green, the chief executive of the Royal Society of Medicine) who seek fame and fortune in a land in which their roots are shallow and who believe that the "New Jerusalem" in medicine is about the creation of an elite group detached from the day to day concerns and experiences of doctors at work.

Better, I suggest, for the profession to turn to existing bodies, particularly the royal medical colleges and the BMA, and insist that they address the central issue of effective leadership of the profession. The good news is that this process is under way. We would therefore be well advised to stay together and resist further fragmentation.

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1 Smith R. Does Britain need an academy of medicine? *BMJ* 1996;312:1374-5. (1 June.)

New confidential inquiry established into homicides and suicides by mentally ill people

EDITOR,—The confidential inquiry into homicides and suicides by mentally ill people has been re-established at the University of Manchester, and changes to its methods are being introduced. One of the most important changes concerns the way that suicides by people with mental illness are identified by the inquiry. The new system of notification of suicides and the subsequent collection of data will rely on the cooperation of directors of public health and mental health services throughout England (equivalent plans exist for Scotland, Wales, and Northern Ireland).

The change is necessary because of substantial underreporting of suicides to the previous inquiry, which relied on notification by psychiatrists and local audit coordinators. In the 18 months covered by its report it obtained information on 240 people[1]; according to research in Greater Manchester, this represents about a tenth of suitable cases. More serious is the probable bias in this sample. The sample seems likely to have omitted in particular those suicides that occurred after loss of contact with services or after difficulties in the provision of care—exactly the cases that the inquiry needs to include if it is to fulfil its main purpose of recommending strategies for preventing suicide for mental health services. So, although notification by clinicians and audit staff will still be welcome, it will not be relied on.

The new system is a version of one that has proved successful in research in Manchester.[2] After a coroner's inquest the director of public health in the district of residence of the person who has died is notified of the death by the local registrar. The inquiry is asking district directors of public health to forward information on all suicides and probable suicides (open verdicts and deaths from undetermined cause). In an average district of 450 000 people there will be around four cases a month.

By checking information on each case against records held by mental health services the inquiry will identify those with a history of contact with the services in the year before death (this remains the main criterion for inclusion) and the consultant psychiatrist whose team was involved. The psychiatrist will be asked to hold a multidisciplinary review of the case (many already do so) and to complete a standard form.

The inquiry's new method is not perfect. There is, for example, a delay of three to six months before most inquests, although this drawback is outweighed by the advantage of an objective definition of suicide. No current alternative, however, can provide comprehensive national data. The inquiry presents unique opportunities in the prevention of suicide, and this partnership of public health and mental health offers it the best possible foundation.

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1 Royal College of Psychiatrists. *Report of the confidential inquiry into homicides and suicides by mentally ill people.* London: RCP, 1995.
2 Dennehy JA, Appleby L, Thomas CS, Faragher B. A case-control study of suicide in discharged psychiatric patients. *BMJ* (in press).

Mobile surgery

EDITOR,—The other day, during a short surgery consultation, one of my patients received and dealt with two business calls on his mobile telephone, without an apology. Is this a record?

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Correction

Evidence based general practice

Owing to an editorial error, only one author is given for the authors' reply in this cluster (13 July, pp 114-5); there were in fact six authors. The complete list of authors should have read: Paramjit S Gill (senior lecturer), department of primary care and population sciences, Whittington Hospital, London N19 5NF; A C Dowell (director), R D Neal (research fellow), P Heywood (deputy director), A E Wilson (lecturer), Centre for Research in Primary Care, Leeds University, Leeds LS2 9LN; and N Smith (general practitioner), Birchwood Medical Practice, Lincoln LN6 0QQ.