Huntington's chorea are not voluntary or intentional. However, I think that most people would also recognise that much of psychiatric practice is concerned with behaviour that is. Any procedures concerned with managing or influencing voluntary behaviour are surely legitimate subjects of vigorous debate.

JOANNA MONCRIEFF, *Research Fellow and Honorary Senior Registrar, Section of Epidemiology and General Practice, Institute of Psychiatry, London SE5 8AF*

Continuing Professional Development

Sir: Gethin Morgan (*Psychiatric Bulletin*, May 1998, **22**, 330–331) provides an interesting insight into his role as Director of the Continuing Professional Development programme. Implicit in his article is a reluctance on the part of psychiatrists to engage in the process of CPD, and he explores issues of cost, time and perceived relevance as aetiological in this motivational disorder. He also touches on the issue of making CPD mandatory.

Psychiatry has always attracted iconoclasts to its profession, and it is perhaps a sign of psychological health that a curmudgeonly group of individualists resist the attempt of their professional organisation to control them. At a time when senior psychiatrists are taking early retirement in droves, and recruitment to the profession is falling, it would seem counter-intuitive to raise the standards required in order to practise. If this remains the College's aim, there are few carrots or sticks at its disposal. Inclusion on a White List of participants would seem an inadequate carrot. Exclusion from roles carrying little financial incentive, such as clinical tutor, would seem a brittle stick.

The most potent motivator would surely be to link CPD to the merit award system, and make the holding of such awards contingent upon an adequate engagement in the process of CPD. This would also bring the focus of the merit award system away from academic or managerial success, and back to clinical excellence, where it surely belongs.

JOHN FARNILL MORGAN, *Department of Mental Health Sciences, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE*

Sir: Professor Morgan wishes to spend his second year as Director of CPD, developing and evaluating the College's CPD scheme, and I think that if he did, there would be less need to persuade clinicians to join. I also think it should be possible to offer advice without being part of the scheme at the moment (my own position).

Let us distinguish between CPD, and the College scheme. All clinicians recognise the importance of the former, and would welcome anything which facilitated their own CPD. Most recognise the need to monitor their professional activities in an open and defensible way. However, most do not wish to pay a fee for a service which the College should provide as a core function (as do most others), nor to pay for something which (currently) delivers no perceived benefit. (The spectre of cost effectiveness is inescapable).

The College scheme should be easy to use, free at the point of delivery, actively evaluate and credit local as well as national events and activities, and be of relevance to all sub-specialities.

Were this the case, Professor Morgan would be inundated with applications to join the scheme, and until it is, he faces an uphill task.

ANTHONY E. LIVESEY, *Consultant Child Psychiatrist, Child, Adolescent and Family Therapy Service, Edmund Street Clinic, Newbold Moor, Chesterfield, Derbyshire S41 8TD*

Administration of electroconvulsive therapy by general practice vocational trainees

Sir: The College officially frowns on general practitioner (GP) vocational trainee scheme trainees administering electroconvulsive therapy (ECT). This view is expressly stated in their training video and reiterated by Duffett & Lelliott (1998). In their recent audit, hospitals which include GP trainees in their ECT rotas were 'marked down'. It is far from clear, however, whether this attitude is justified.

It is expected that during their hospital posts, GP trainees participate in the activity of each speciality. They are fully involved in its day-to-day clinical work and the relevance or otherwise to general practice is usually a secondary consideration. ECT is not a technically demanding procedure which requires years to master; training and experience in its administration can be gained during a six-month placement. Moreover, such experience can be of great benefit to depressed patients seen later in primary care. A GP who has had 'hands-on' experience of any procedure is in a good position to answer questions or allay fears.

The continuing stigma surrounding ECT can be addressed by ensuring that GPs are conversant with its use. Otherwise how can we expect the general public to change its views?

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DUFFETT, R. & LELLIOTT, P. (1998) Auditing electroconvulsive therapy. The third cycle. *British Journal of Psychiatry*, **172**, 401–405.

JONATHAN HILLAM, *Consultant Psychiatrist, King's Lynn and Wisbech Hospitals NHS Trust, Queen Elizabeth Hospital, Gayton Road, King's Lynn, Norfolk PE30 4ET*

Medical staffing crisis in psychiatry

Sir: I read with interest the article by Rachel Jenkins and Jan Scott (*Psychiatric Bulletin*, April 1998, **22**, 239–241).

Traditionally, it has always been difficult for British doctors abroad to return to work in the UK because of the merit award system. Regardless of rank or reputation the doctor had to start at a C award level and then work up over years to an A. This meant a considerable drop in income. When I thought of doing this almost 20 years ago I could expect to be paid the same pay at that time as my Toronto secretary. Does the arcane merit system still exist in the National Health Service (NHS)?

Now, we have the T award from the European Union. Again, regardless of rank or reputation the doctor abroad has to make a special application with references. This, despite people like myself having been born and educated in the UK. Without this specialist marker a doctor may find it hard to practise in the NHS or privately.

Finally, psychiatry is becoming less popular in the USA as a speciality. Less young medical graduates are being recruited – it probably has something to do with money. Psychiatrists earn a lot less than surgeons or internists with procedures, nevertheless they still earn more than British psychiatrists in the UK. So in the US, we have a shrinking group of psychiatrists who are well paid in European terms, US $100 000–150 000 per annum, but poor for specialists in the USA.

So it can be seen that in the past and in the present luring British expatriates or American psychiatrists to the UK is not easy.

ROBIN EASTWOOD, *Professor of Psychiatry, St Louis University, Health Sciences Center, School of Medicine, 1221 South Grand Blvd, St Louis, MO 63104*

Sir: It is increasingly recognised that there are difficulties in filling jobs in psychiatry at consultant and specialist registrar levels (*Psychiatric Bulletin*, April 1998, **22**, 239–241). The difficulty is more apparent depending on the speciality, and the place of work or catchment area (inner city and rural areas).

Some suggestions for solutions are:

(a) Creating some financial inducement, for example guaranteeing that every consultant by the end of their services (between the ages 55 to 60) will receive the full five discretionary points.
(b) Creating some flexibility within the psychiatric sub-specialties without hindrance by the Royal College of Psychiatrists' representative.
(c) Emphasising the clinical leadership of the consultant psychiatrist within mental health service structures, something which has been eroded in recent years. A statement by the Royal College of Psychiatrists and the National Health Service Management Executive would be very useful in this respect.

EMAD YOUSIF, *Consultant Psychiatrist, New Possibilities NHS Trust, New Possibilities House, Turner Village, Turner Road, Colchester, Essex CO4 5JP*

A note of qualification

Sir: The consultant psychiatrist Mr C. Psych. identified by Bronks (*Psychiatric Bulletin*, May 1998, **22**, 327) is presumably a relative of Mr D. Phil, a co-author who mysteriously appears on some research papers originating in Oxford.

PAUL J. HARRISON, *Clinical Reader in Psychiatry, University of Oxford, Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX*

Data pertaining to the Mental Health Act, 1983

Sir: We have been commissioned by the Department of Health to perform a systematic review of all data pertaining to the Mental Health Act, 1983. In order to avoid publication bias, we would like to invite any readers who have unpublished data (including audits into the use of the Act) to contact us so their data can be included in the final report. Any reader with such data should contact Ms Wall at Department of Psychological Medicine, King's College School of Medicine and Dentistry and the Institute of Psychiatry, 103 Denmark Hill, London SE5 8AZ: e-mail s.wall@iop.bpmf.ac.uk.

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