led to confrontations but the matter has not been resolved and is obviously detrimental to patient care. An element of 'democracy' has been introduced in the overall medical care of patients and the doctor has found himself in the minority with his views ignored and often overruled. Although the Responsible Medical Officer, he has been placed in a dilemma by not being able to give the patient the best possible medical treatment. The DHSS has never clarified this matter. This erosion of clinical autonomy is making a mockery of patient care as it gives the doctor responsibility but not authority in the treatment programme.

In the 'long-stay hospital' the situation has become acute, especially in view of the closure programme. No longer are the RMO's views on patients' suitability for transfer or discharge sought. Deficiencies in paramedical services for hospital patients remain unremedied and the doctor's dream of upgrading medical care and treatment remains unfulfilled. Such despair cannot be a good thing for the National Health Service as a whole or the country at large.

U. J. DEY

Brockhall Hospital
Old Langho
Nr Blackburn, Lancs.

Current norm for consultant psychiatrists in mental handicap

DEAR SIRS

I am writing to express concern regarding the current norm for consultant psychiatrists in mental handicap (*Bulletin*, April 1988, **12**, 155) and the College's role to influence at Regional level some of the 'overloaded' jobs. The current norm of 1 to 200,000 is at least over a decade old and it was expected that the College would have recommended an improved figure of at least 1 to 100,000 if not better, parallel to other subspecialties of psychiatry. At present in East Dorset (Bournemouth) there are 11 general psychiatrists, two psychogeriatricians and three child psychiatrists against one consultant psychiatrist in mental handicap for a population of 430,000.

I would like to generate a constructive argument about some of the posts having catchment areas of over 650,000. How can one do justice to the services with this sort of catchment area? I am sure that the job descriptions of this kind of post must have gone through for an approval to the Regional Adviser in Psychiatry or the local professor's department. They should either force the Region to improve on the job or refuse to give College support and approval for the job description. In certain districts the job description is changed after approval of the job for advertisement, which I feel should be considered seriously, and the Regions should be advised not to do that and instead re-submit the job description for approval. The College's representative on the Appointment Committees should also look into these factors as the candidates cannot always grasp all information on a preliminary visit and may not be aware of 'grey' areas of the job.

I would suggest the following:

1. change the norm to 1 WTE to 100,000
2. strict screening of job description before approval and advertisement
3. frequent review of the situation
4. if possible to 'blacklist' the Region or District which does not improve the job descriptions or comply with the College guidelines.

G. S. SARNA

East Dorset Mental Handicap Services
Bournemouth

Appropriate use of Sections 2 and 3 of the Mental Health Act 1983

DEAR SIRS

In my letter (*Bulletin*, November 1987) I said that I would welcome a statement from the Commissioners on the controversial matter of the appropriate use of Sections 2 and 3 of the Mental Health Act 1983, and that I hoped that their recommendations would be on the lines set out by Dr Aaronricks (*Bulletin*, June 1987). I would therefore like to welcome the letter from the Chairman of the Mental Health Review Tribunals (*Bulletin*, May 1988). As may be surmised from my correspondence, I am totally in agreement with the distinctions made by the Chairman between the appropriate use of Section 2 and Section 3 and if I may be so bold as to speak for Dr Aaronricks, I believe that these were the distinctions that he was also emphasising in his correspondence.

DONALD BERMINGHAM

Hinchingbrooke Hospital, Huntingdon
and Fulbourn Hospital, Cambridge

Wider use of benzodiazepines

DEAR SIRS

The statement on benzodiazepines which you published in the *Bulletin*, (May 1988, **12**, 205) is quite misleading. It reads as if benzodiazepines are only used as anxiolytics and hypnotics, and ignores the wide potential for the use of benzodiazepines in other areas of medicine. Benzodiazepines are widely used in neurological practice, in particular for their muscle relaxant and also anticonvulsant properties. A number of benzodiazepines are now used routinely in the management of epilepsy, including clonazepam and more recently clobazam. The latter drug, a 1,5

benzodiazepine, is structurally different from the majority of other benzodiazepines, and thus possesses a different toxicity profile and spectrum of action. It has powerful anticonvulsant properties which can be usefully used in the management of difficult to control epilepsy, and its anxiolytic properties are associated with minimal effects on psychomotor and cognitive function.

It is on account of such misleading statements that have been published in the *Bulletin* that patients with epilepsy find it difficult to get their appropriate medications, and benzodiazepines generally have been all tarnished with the same brush. This is entirely inappropriate, not the least reason being that it narrows the debate in psychiatry to the area of anxiety only, without recognising the biological underpinnings of the neuroses and the overall spectrum of neuropsychiatric illnesses within which psychiatric conditions may be viewed.

MICHAEL R. TRIMBLE

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DEAR SIRS

May I add my support to the letter of Peter Dally (*Bulletin*, June 1988) on the College statement on benzodiazepines and dependence. It is difficult to make general statements which are universally applicable and those who feel that they have reason to prescribe any particular drug feel very vulnerable if there is an official publication from their elected representatives advising them not to do so.

I do not wish to enter into a debate into the particular merits or demerits on a whole class of drugs so much as to regret a situation whereby responsible colleagues are put at great hazard for doing what they have sensitively and competently considered to be appropriate. It is the more unfortunate where it is not a prescient caution which is being given, but simply one which amplifies the difficulties created by an increasingly litigious public and their vociferous legal advisers.

MALCOLM WELLER

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Training implications of the move towards community oriented treatment

DEAR SIRS

The College has recently set up a Working Group to report on the training implications of the move towards community oriented treatment. The membership includes the Dean and representatives of the Education Committee, Manpower Committee, JCHPT, CTC and Social and Community Psychiatry Section. We hope to base our report on a wide body of information and opinion, and we should be interested to hear from any of your readers who have experience in this area or who wish to draw particular issues to our attention. Correspondence could be addressed to me at the College and would be most welcome.

DAVID JULIER

Sub-Dean

A 'domiciliary' visit

DEAR SIRS

I would be grateful for the guidance of some of your more experienced readers on an extremely tricky point of psychogeriatric practice.

I have been asked by the local authority to make a 'domiciliary visit' to an elderly man who is normally to be found, asleep or awake, in the ticket-hall of Camden Town Tube Station. It is proposed that he should consult me (or I him) *in situ*, he having appeared to express some unwillingness to move elsewhere. My dilemma is whether Camden Town Tube Station (hereafter to be referred to as CTTS) is a 'domicile' or 'place' within the meaning of my Terms and Conditions of Service; I have read these carefully and can find no specific guidance on the matter.

It could be argued that CTTS is undoubtedly a 'place'. By contrast, for example, were the patient to embark upon a journey by the Northern Line at any time during the consultation, he could not then be said to be occupying a 'place' and therefore any part or parts of such a consultation that took place during such a journey could not, *ipso facto*, be said to constitute a 'domiciliary visit'.

Again, it could be argued that, to all intents and purposes, CTTS is *for the time being* the domicile of the patient. On the other hand, it could be said that for CTTS to be regarded as the legal and therefore the true domicile of the patient there would have to exist a formal tenancy agreement between the patient and the Station Manager, and I understand that no record of such agreement or contract can be produced.

Finally, will London Transport pay my domiciliary fee? These are serious questions requiring answers.

R. M. FRASER

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PS. Anyway, when I arrived he had moved – to the foyer of Barclays Bank opposite, which he finds more secluded.

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