the issue of South African Psychiatry'. This is unjustified and gratuitously offensive. The College has condemned misuse of psychiatry in the Soviet Union (Quarterly Meeting, November 1978), torture in Northern Ireland (*Bulletin* June 1977, p. 11), and the effects of apartheid in South Africa (*Bulletin* June 1983, **7**, 115). The College pointed out 'that there is substantial evidence that discrimination in the provision of psychiatric services based on race exists in South Africa both in State and Private Hospitals and that this discrimination in the provisions of psychiatric facilities on the grounds of race is to us totally unjust and unacceptable.'

If the Statement by the Society of Psychiatrists proves to be solely 'a cynical attempt to appease Western opinion' (and I hope it is not), then it will be for Dr Sashidharan to show that this is the case. The College's Special Committee on Abuse of Psychiatry can deal only with factual evidence, not opinions. Council has never been involved in 'the endorsement of psychiatric practices in the Republic', as Dr Sashidharan states. It welcomed a statement which positively condemned the ill effects of apartheid. Dr Sashidharan is entitled to promote his views and opinions vigorously. These will carry more weight if he is factually accurate and does not misrepresent the views of Council.

Mental Health Act 1983 (Consent to Treatment): A personal view

DEAR SIRS

The Mental Health Act 1983 ostensibly addresses the issue of consent to treatment, but does little to eradicate the difficulties associated with the treatment of those (severely handicapped) incapable of giving such consent.

Allow me to cite two current cases, which I believe highlight some of the deficiencies associated with Section 58 of the Act. The first concerns a severely handicapped adult (of informal status) in whom dental treatment was advised at a recent case conference. Both the Mental Health Commission and the legal adviser to the Health Authority were unable to furnish definitive advice on whether or not to proceed, although the former were able to confirm my belief that such treatment was in any event outside the scope of the Act.

The second case concerns all those (severely handicapped) residents within the hospital who are receiving long-term oral medication. A recent visit by the Mental Health Act Commission suggested that such residents should be 'sectioned' in order that this treatment may be legally given. This advice in turn raises more questions than answers, most notably: (a) Is it justifiable, or legally correct, to invoke the Act, where it is clear that treatment is proceeding on an informal basis, and without any overt protest or objection (thus negating at least one prerequisite of Section 3)? (b) If the Act were invoked, would this enhance the rights of the individual by ensuring a second opinion (provided for under Section 58) from the Mental Health Commission, or simply result in an otherwise informal patient being unnecessarily 'sectioned'?

It is clear that treating informal patients (incapable of giving informed consent, albeit with the consent of their next of kin) under common law, where a definitive legal position is lacking for either party, is unsatisfactory to both patient and care givers alike.

Although provision is allowed for within the Act for such forms of treatment as may be specified by regulations made by the Secretary of State, the Act as it now stands is insufficiently comprehensive in specific terms to deal with the former issue of dental treatment, or inappropriate in the latter case (of drug treatment exceeding three months).

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Trainees and research

DEAR SIRS

In 1980 Dr Helena Waters, then Chairman of the Collegiate Trainees' Committee, surveyed trainees in the Southern Division, at the request of the Executive Committee, to determine the extent of trainee involvement in research. The results of the survey have never been published, but we feel they might usefully be reported in the *Bulletin* as it would interest us to know whether other Divisions have any comparable figures, obtained before or since 1980, which may help to suggest how the situation is developing.

The survey

Four hundred questionnaires were sent to trainees in the Southern Division. Trainees were asked for information about their grade, the hospital in which they were working, their interest in and current involvement in research, and the availability of facilities and supervision for research.

There was a 25 per cent response rate. Replies were received from 16 SHOs, 51 registrars and 28 senior registrars. For the purposes of analysis the trainees were divided into junior trainees (SHOs and registrars) and senior trainees (senior registrars).

The majority of junior trainees (76 per cent) and senior trainees (86 per cent) who completed the questionnaire were based in teaching hospitals. The vast majority (93 per cent) also expressed an interest in undertaking research. At the time of completing the questionnaire, 32 of the 67 junior trainees (48 per cent) and 22 of the 28 senior trainees (79 per cent) were currently engaged in a project.

Junior trainees based in non-teaching hospitals were almost as active in research (44 per cent) as those in teaching hospitals, but this was not so at senior registrar grade where all reporting involvement in research were based at a teaching hospital. Roughly a quarter of both groups were registered for an MPhil or a PhD, and all these were at teaching hospitals.

Fewer junior trainees (39 per cent) than senior trainees (68 per cent) reported that adequate supervision was available, and a small number of trainees (22 per cent of juniors and 4 per cent of seniors) had been unable to arrange supervision when trying to begin a project. Thirty-three per cent of junior trainees and 64 per cent of senior trainees felt that there were adequate research facilities (i.e. access to statistical advice, computers, etc) available to them locally.

Comment

The relatively low response rate (25 per cent) and the skewed distribution of responses, with the predominance of teaching hospital trainees, casts doubt as to how representative the respondents are of trainees in the Southern Division. In addition, the majority of the respondents were interested in and engaged in research. Whilst reassuring in one way, it tells us nothing about the majority of trainees, who did not reply. One can only speculate, but the respondents may be a self-selected group interested in research, and therefore motivated to reply to the questionnaire in order to assist the 'research' of others.

Previous articles[1,2] have drawn attention to the importance of adequate constructive help for trainees new to research. There is a suggestion that this study supports this view with the majority of junior trainees reporting inadequate supervision and almost a quarter unable to arrange it. It was also of note that junior trainees were perhaps less able to determine the availability and adequacy of research facilities, as they rated these as less satisfactory than did senior trainees. This may also reflect the relative inadequacy of supervision and guidance for their stage of development.

Although most trainees were based in teaching hospitals, there was, no evidence that placement in one conferred an advantage, as amongst junior trainees there was no great difference between the proportions involved in research.

In summary, the finding that the majority of the trainees who replied were involved in research is superficially reassuring but leads to questions about the poor response rate and whether this is related to lack of interest or involvement in research by the majority of trainees in the Division. The perceived lack of 'adequate' supervision by junior trainees may reflect a situation in which the supervision offered is inappropriate for the needs of the trainees.

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The validity of the Membership Examination

DEAR SIRS

Following the recent results of the Membership Examination, I hope that the newly elected members of the Collegiate Trainees' Committee will look first at this method of testing those they represent.

The point is not that it was a fundamental error to model the examination on the MRCP, which has so often seemed to reward robust self-confidence (justified or otherwise), familiarity with the obscure and simple luck. The point is not that most postgraduate exams confuse a high rate of failure with a high rate of discrimination, although many will doubt the reliability of a test which had previously failed this year's Laughlin Prize winner and which has now failed the candidate who has just won the Gaskell Medal. Nor is it that the use of videotaping should have before now led to the abandonment of the anachronistic reliance on live (and therefore varied and unpredictable) interviews. And it is not that suitability for higher clinical training cannot be assessed in circumstances as removed from normal clinical practice.

The point is simply that all these things are apparent to the most naive observer of human behaviour and should have been clear to psychiatrists long ago.

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DEAR SIRS

In the course of a teaching session during a Journal Club Meeting with trainees, I had a very interesting and controversial argument about the need for taking an ECG as a requirement for investigations for lithium therapy and the frequency of monitoring of serum lithium levels for a stabilized patient on lithium therapy.

The trainees gave different answers, quoting from different authoritative textbooks. Now, as the multiple choice questions require specific answers and the marking system takes account of these specific answers only, it is crucial for the trainee to answer correctly if he or she is to obtain positive marks. As we all know, the state of knowledge in the field of psychiatry is still in flux and there are as many possible answers as there are questions, so the validity of the multiple choice question becomes questionable and consequently that of the examination. Naturally, the loser in such a situation is the trainee who is taking such an examination.

Perhaps the Examining Body of the College ought to review seriously the 'multiple choice question' type of examination and make appropriate amendments in the written part of the examinations.

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Deinstitutionalization in the USA

DEAR SIRS

Dr Fagin is surely right to draw our attention to the lessons that we in Britain may learn from the experience of the deinstitutionalization movement (bandwagon?) in the United States (*Bulletin*, June 1985, **9**, 112–114). It should not be forgotten that in England and Wales at least there has been a very substantial run-down in the in-patient psychiatric population, albeit less precipitate than that which has occurred in America.

Several additional points emerge from the American literature that may be useful as we contemplate the large scale closure of mental hospitals and their replacement by networks of 'community-based' services. Firstly, mental hospitals serve the needs of the most severely handicapped patients in ways