to his personal failure in duty'. He had responsibility without power, his role in security being that of co-ordinating, and there was no evidence that he had ever frustrated attempts to tighten security. Neither was there found to have been any problem in administration caused by the Physician Superintendent also being Professor of Forensic Psychiatry at Edinburgh University.

The Report further criticizes the in-service training in security for nurses, and it is recommended that a Security Officer be appointed. The Management Committee had previously refused to accede to staff's demands for such an appointment, fearing that if the responsibility for security was vested in one man others might slacken their personal responsibilities. The Sheriff points out, however, that one of the most important duties of such an officer is to promote such feelings of personal responsibility among staff.

Besides neglect of security, the staff had blamed the murders on the progressive treatment regime, the introduction of more humane staff-patient relationships and the system for granting parole. (Parole in Special Hospitals involves granting of certain privileges, such as moving about unescorted within the hospital's grounds; it is therefore quite distinct from the prison parole system).

Many believed that the hospital's Managers, and one of the consultants, paid little regard to their experience and their wish to be consulted about treatment. The Report says: 'It is hardly possible to over-estimate the resentment this caused. No feeling is more corrosive to conscientious men than that their views and, by inference, they themselves are held in low esteem by their superiors.'

The Report examines problems of communication between and among doctors, nurses and occupations officers, though there is no reference to problems of communication among the doctors themselves. The Sheriff recommends the appointment of two nurses to the Management Committee and a re-examination of nurse staffing and their shift system.

The complaints about lack of communication between certain of the doctors and their nurses leads to the comment that one of the consultants' 'informal methods' did not command the respect of the nurses, who considered them too desultory to be of much use. The same consultant's 'aloof style of treatment' and practice of seeing patients infrequently is examined, and it is concluded that the team approach has many advantages from the standpoint of security and should be adopted, though it is recognized that this recommendation 'might be thought to encroach on the right of doctors to determine the treatment of their patients'.

The Scientologists appeared at the Inquiry under their various guises and contended that the Section of the Scottish Mental Health Act relating to withholding of correspondence was operated oppressively by doctors thereby preventing patients making complaints. The Report points out that the Mental Welfare Commission has a duty to inquire into any complaints, and no letters to that independent body can be withheld. The Scientologists are held to have not behaved responsibly, and their activities lead the Sheriff to say 'nothing could be more cruel than to foster false hopes or more dangerous than to fuel the resentment of patients who believe they are wrongly detained.' As a final stroke he did not award them their expenses.

In conclusion, the Sheriff acknowledges the work of the hospital: 'The staff do work which few of us would consider undertaking and they do it with steady dedication.' As the late Dr Peter Scott (who contributed towards the drafts of the Report before his untimely death) told the Inquiry: Special Hospital patients are those whom not only society have rejected, but ordinary hospitals and prisons cannot manage; it is therefore inevitable that such hospitals will be beset by major problems. Medical and nursing staff are to be congratulated on their difficult but essential public work, as the Report says, and the nursing unions should recognize that a tightening of security is not inconsistent with progressive treatment regimes but rather that the two must inevitably go hand-in-hand.

J. R. HAMILTON

Report on the Third European Liaison Meeting on the Prevention and Control of Road Traffic Accidents. Regional Office for Europe, WHO, Copenhagen.

Around 1974–5, according to WHO statistics, some 70,000 persons were killed and probably another 1,700,000 injured on the roads of Western Europe. There is little reason for thinking that these figures have been significantly reduced in the intervening years, and this Report gives some clues to why progress in road safety is so disappointing.

A special Appendix is needed to list full titles of the 68 organizations whose initials are scattered liberally throughout the text. Faced by such a multiplicity of independent bodies it is scarcely surprising to read, 'That with respect to liaison between the organizations represented at the second meeting in 1971 there has been little improvement.'

Some of the more revealing comments appear in the first eleven pages of this Report. There is still no uniformity in reporting of deaths and injuries; at one extreme accidental death is only included if it

occurs at the time of impact, whereas in most countries road deaths are recorded if the individual dies from injuries received at the time within 30 days of the accident. Human factors, we read, are solely responsible for at least two-thirds of accidents. Children are particularly at risk, and reference is made to their problems, 'in learning to adapt to the road system'. The possibility that the system might be adapted to the needs and safety of children gets relatively little consideration. However, it is in the field of prevention that failure is most apparent. For example, some countries have spent large sums of money with little in the way of benefits in terms of reduced accidents and casualties, yet the member states seem unable to reach agreement on the compulsory wearing of sash and lap seatbelts, which are inexpensive and save many lives. Sometimes purely chance events have improved road safety far more effectively than planned measures. The strike of workers in the liquor industry in Sweden, for example, was singularly effective in reducing road casualties while it lasted, but unless total prohibition is to be introduced into all countries events of this kind can have only a temporary effect.

The greater part of this Report consists of resolutions and recommendations which, in the light of past experience, have little prospect of being put into effect. As the Report says, acceptance of specific road safety measures is sometimes influenced more by political and other factors than by economic considerations. Anyone who has tried to persuade the elected representatives of the people to introduce random testing of drivers for their alcohol content will appreciate the point of that remark.

Of some interest to psychiatrists and psychologists is the recommendation that techniques for identifying high-risk individuals—particularly drivers—should be developed and that psychometric techniques might be employed to detect drinking drivers. In fact, past work has indicated all too clearly who is most at risk without the need for complex psychological procedures. The aggressive psychopath at the wheel—drunk or sober—is a regrettably familiar phenomenon, but no authority is willing to introduce legislation to keep him off the road or to prevent him driving again once his dangerous behaviour has come all too disastrously to official attention.

Judging by past experience, attempts to control the human factors contributing to road crashes have been singularly unsuccessful. Perhaps it is time to stop doing further research in the area and ask the engineers to provide well thought out schemes in terms of vehicle design, speed controls, urban planning and other measures to separate vehicles from pedestrians and vehicles from each other. Their implementation will probably be expensive, but they might save far more lives than our continued attempts to 'crack down' on drinking drivers of whom only about 1 in 2,000 is detected each year. However, by the time the engineering solutions are put into effect we may well have run out of fuel anyway. In the meantime, perhaps we could hardly do better than heed the paraphrased advice of Pubilius Syrus—'Every day we should drive as if it were to be our last.'

F. A. Whitlock

CORRESPONDENCE

PROVIDING FOR SPECIAL INTERESTS IN A DISTRICT PSYCHIATRIC SERVICE

Dear Sir,

Dr Ekdawi argues eloquently in the *Bulletin* (March 1978) for inclusion of Rehabilitation as a special interest for future consultants in a District Psychiatric Service.

Bennett (1967) pointed out that schizophrenics 'occupy one-sixth of all hospital beds in England and Wales'. (The number of beds may have decreased since then but the number of schizophrenics certainly has not.) This makes schizophrenia far and away the biggest unsolved problem whose sufferers require lifelong medical care. Rehabilitation is the appropriate form of that care, but it and chronic schizophrenia do not appeal to most psychiatrists.

At a recent appointment committee for a consultant post with a special interest in rehabilitation there were two candidates. Each had the M.R.C.Psych. and was well versed in general psychiatry. Neither knew anything about rehabilitation (my opinion, confirmed by the Professor of Psychiatry). Somebody had to be appointed and one was. Hard luck on his chronic patients.

This episode reflects badly on standards of training, of examination and of care. The only evident explanation is that doctoring schizophrenics attracts no prestige within the profession. Patients and their