the Committee of Inquiry into complaints about Ashworth Hospital, my views may help initiate debate on measures needed to rectify the abuses identified in the report. However, I would add that my contacts with the hospital were from 1977 to 1986, when it was known as Moss Side Hospital, when I furnished over 50 independent psychiatric reports to the Mental Health Review Tribunal.

I was horrified by the intimidating atmosphere, the rule of thumb diagnoses, the punishment of patients for applying to the Tribunal, the victimisation of the very few nurses who tried to form therapeutic relationships with patients and the lack of treatment other than medication. Patients very seldom went on leave and then it was escorted. There were no rehabilitation facilities. The vast majority of the patients whom I saw were inadequate personalities who had never been dangerously violent and in the hospital for over seven years for minor offences. In several cases, it was as a result of television programmes that they were discharged.

In my opinion Ashworth Hospital, and other Special Hospitals, are irreformable and should be closed. The small number of really dangerous patients should be treated in small units, run on therapeutic community lines, with a high staff patient ratio and specially trained staff. The remainder should be assessed by experts from outside the institution. It will be found that many are suitable for sheltered villages on the lines of the Camphill villages. Others could be treated at the Henderson Hospital.

MAIRE O'SHEA

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DEAR SIRS

Dr Maire O'Shea has expressed her strongly worded concerns about the special hospitals and remarks that no other readers of the *Bulletin* have as yet responded to the content of the report of the Committee of Inquiry into complaints about Ashworth Hospital.

In fact the Forensic Section and the Council of the College has in recent months made several responses but perhaps these need to be more widely publicised.

At the President's request, Professor Arthur Crisp convened a group which has provided a detailed commentary on the implications of the report, with special attention to the duties and responsibilities of psychiatrists in Special Hospitals. The College had adopted as an official College report, a paper which was submitted to the Department of Health for consideration by the Reed Committee High Security Working Party. In that it does recommend *inter alia* that no consultant psychiatrist should have a caseload larger than 45 patients, that the special hospitals should be reduced in size and that the total number of places should be reduced from approximately 1,700 to 1,000. The SHSA has repeatedly expressed its concern that many patients resident in special hospitals remain there unnecessarily and has urged local psychiatric services to remedy the situation which has many features in common with those in the Irish Republic. The vexed questions about whether personality disordered patients should be treated in hospital and, if so, by what means, has been considered by another Reed working party to which the College has contributed. One contribution was a most useful research paper from Dr Rosemarie Cope which clarified current opinion among forensic psychiatrists. Some shared the kind of therapeutic optimism which Dr O'Shea appears to have.

My own personal opinion is that all of us aware of the problems in special hospitals and who did so little to remedy them should pause before indulging in any ill-considered criticism of colleagues working in special hospitals who not only grapple with very difficult clinical problems but with institutional arrangements which are unhelpful.

JAMES A. C. MACKEITH
*Chairman, Forensic Section*

## *Co-ordination of exams*

DEAR SIRS

Talking to other trainees who recently sat the MRCPsych, I noticed that we all experienced a prolonged period of uncertainty during the exam and when awaiting the result. For Part II the time between sitting the written exam and receiving the result was eight weeks with three weeks between the written and clinical part.

Sitting an exam is unpleasant and causes anxiety and stress to the candidate. Not only are the candidates themselves affected, but also their ability to function at a normal level at work and to relate to colleagues and patients.

Due to the late notification of the exact date of the clinical exam, it is virtually impossible to give appointments to patients for three consecutive days, which can affect the service quite severely. I can see no reason for not having a date for the clinical exam from the outset, as proceeding to sit it does not depend on the result of the written papers.

Also, why is the wait for the result so long? The clinical exam is marked on the day and the MCQ papers marked by computer, leaving only the essay and short answer question paper to be marked by examiners.

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