The *Annual Census of Psychiatric Staffing* (Royal College of Psychiatrists, 1995, 1996, 1997) reports reasons for consultant vacancies such as retirement, new post provision, moving to a different post and a miscellaneous 'other' group. For the years 1994 to 1996 for England, Wales and Scotland, the proportion of consultant psychiatrist taking retirement (excluding on illness grounds) and leaving a vacant post has reduced from 24.5 to 13.7% of the total vacant posts across all specialities. While some vacancies arise from provision of new posts (18.9 to 20.5% from 1994 to 1996), other than the other/miscellaneous group (36.9% in 1996) the largest proportion (22.4% in 1994 to 23.0% in 1996) are due to consultants taking different posts. This is backed up by data from College Assessors' reports on Consultant Advisory Appointment Committees for 1996 suggesting that the successful applicant was already a consultant in, for example, 47.1% of general adult psychiatry appointments.

I would speculate that vacant posts will become a hard core of 'difficult-to-fill', unappealing jobs since colleagues have either retired early from them, or others have moved from them to more attractive or lucrative positions. Therefore I would suggest that it is not just a question of tempting back prematurely retired colleagues of persuading more doctors to enter psychiatry (Storer, 1997) but encouraging trusts to be creative in their initiative to encourage current postholders to stay or prospective ones to apply.

ROYAL COLLEGE OF PSYCHIATRISTS (1995) *Annual Census of Psychiatric Staffing 1994*, Occasional Paper OP30. London: Royal College of Psychiatrists.
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The Internet and psychiatry

Sir: Senior *et al* (*Psychiatric Bulletin*, December 1997, **21**, 775–778) correctly highlight the importance of the Internet as an aid to psychiatric clinicians and researchers. The World Wide Web (WWW) is a communications phenomenon that could facilitate the detection, management and understanding of mental disorders (Huang & Alessi, 1996).

The Computers in Psychiatry Special Interest Group has a web site (http://www.ex.ac.uk/cimh) that not only provides up-to-date descriptions of computer software useful to psychiatry but also supplies information to people with mental health problems (Littlejohns & Briscoe, 1996). Since 1997 the site has posted the College's acclaimed "Help is at Hand" leaflet series, found at http://www.ex.ac.uk/cimh/help.

Covering topics ranging from alcoholism to schizophrenia, they provide clear information about disorders supplemented by contact addresses and telephone numbers of relevant national support organisations. The site is visited about 2000 times per week. As computers become fully integrated into everyday life, Internet-based educational material will prove an invaluable information source for people with mental health problems.

The College has demonstrated an awareness of the opportunities afforded by the WWW. It has an obligation to ensure these opportunities are optimised to the benefit of those who need them. To this end, we are pleased to report that meetings are taking place to plan the development of a College site. We would be pleased to hear from Members with ideas about what such a site should contain.

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Risk assessment

Sir: Guidelines like the recent College report on risk assessment and management (Royal College of Psychiatrists, 1996) are frequently considered codes of professional practice in legal proceedings when something goes wrong. The report mentions that some factors are unreliable predictors of risk to harm to others. I am concerned about the validity of most of the factors included in the assessment and about the false positives likely to be detected as a result. Moreover, diagnostic categories have not been discriminated: 'psychiatric patients' is the term used throughout the report. Thus, there is an implicit inclusion of psychopathic disorder (used here as defined in the Mental Health Act 1983, and when psychopathic disorder is the main/only diagnosis).

Current classifications do not include psychopathic disorder in the set of (mental) illnesses. Also, the external evidence on the effectiveness of

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therapeutic interventions of psychopathic disorder is at best deficient. I see this indicating that the medicalisation of psychopathic disorder is a regrettable, albeit not irreversible, mistake. Moreover, the inclusion of psychopathic disorder in new legislation and practice guideline may cause a further diversion of resources allocated to the severely mentally ill. The guidelines on risk assessment might unwittingly help many psychopathic disorder persons further misuse psychiatric services and elude the penal system. It is unfortunate that the increasing pressure on the psychiatric field to exert a tighter social control on the mentally ill is being dangerously extended by incorporating those who must not be included.

Interestingly, Coid, a member of the report's working party, observes that ". . . the remit has been widened in the government's guidelines to include diagnostic categories where there is no convincing evidence one way or the other that psychiatric treatment is effective . . ." (Coid, 1996). Yet, some of the listed factors closely resemble features associated with, and criteria used in the diagnosis of, psychopathic disorder.

I hope that future College guidelines on risk assessment have at least explicit indications of the validation of factors included in the assessment of risk, and clearly defined target cases.

COID, J. W. (1996) Dangerous patients with mental illness: increased risks warrant new policies, adequate resources, and appropriate legislation. *British Medical Journal*, **312**, 965–966.

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Psychiatry and the death penalty

Sir: Rob Ferris (*Psychiatric Bulletin*, December 1997, **21**, 746–748) and Peter Hodgkinson (*Psychiatric Bulletin*, December 1997, **21**, 749–750) have performed an important service by bringing attention to the controversial issues raised regarding the role of psychiatry and the death penalty. The points addressed in these two articles extend far beyond the parochial concerns of those of us in the 95 countries, including the United States, that maintain the death penalty. We in the US, benighted in regard to the death penalty, are involved in intense arguments in regard to psychiatrists' participation in executions that have worldwide implications for morality and ethics in medicine.

A number of leading forensic psychiatrists in the US have proposed new principles to make it ethically permissible for psychiatrists to be involved in legal executions. The key rationale, among others, is the concept of 'forensic psychiatry exceptionalism'. This notion asserts that a forensic psychiatrist is not a psychiatrist when performing evaluations for a court and thus is not bound by the traditional ethical principles of most psychiatric societies. As stated by a leading forensic psychiatrist, ". . . forensic psychiatrists, however, work in a different ethical framework, one built around the legitimate needs of the justice system", (Appelbaum, 1996). It is not surprising that forensic psychiatrists have been referred to as 'advocates of justice', as an assistant 'in the administration of justice' or as an 'agent of the state'. This proposal, which should cause dismay to physicians and psychiatrists internationally, makes permissible participation in executions and torture, since the physician may simply state, "I am not bound by traditional medical ethics since I am not acting as a physician". In Illinois in the US, the state legislature has passed a rule that permits physicians to take part in executions, including injection of lethal substances, without losing their licences since in that role they are *not* acting as physicians!

As the two authors point out, this controversy is still unresolved in the American Psychiatric Association (APA). The American Medical Association (AMA) had passed a resolution in June 1995 that paved the way for more involvement of physicians in executions (Council on Ethical and Judicial Affairs, 1995), but the AMA resolution was not approved by the APA Board of Trustees at its meeting in July 1995. Rather, the resolution was referred to various components of the APA for further discussion and recommendations. Recommendations including setting up a commission and holding a debate. The latter was held at the annual meeting of the APA in May 1997 in San Diego. Noteworthy is that in response to a request to modify the 1995 AMA resolution made at the June 1997 annual AMA meeting, the Council on Ethical and Judicial Affairs of the AMA was asked by the AMA House of Delegates to reconsider its position in regard to physician participation in executions. Thus, this issue is in active discussion in both the APA and the AMA, without resolution at the present moment.

The issue of treatment of a psychotic individual on death row is taken up in the 1995 AMA resolution, but in the words of Dr Hodgkinson, that statement is "too loose and equivocal, requiring, for example, a clearer definition of what constitutes 'extreme suffering' ". We endorse the 1992 College guidelines that in the situation where the necessity for intervention

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