curriculum. When our medical school was established in 1981, the teaching of the behavioural sciences course was run by one academic and one clinical psychologist and students' responses appeared unsatisfactory. Over the past two years, psychiatrists have taken over the course, which consists of a variety of lectures on medical psychology and sociology. The general approach is to teach basic psychological and sociological principles, illustrated with clinical examples. When one of us teaches Erikson's life stages during a lecture on 'young adulthood', for example, case histories are freely discussed of patients with depression, anorexia nervosa, etc. to illustrate how the failure to resolve conflicts earlier on in life may result in adult psychopathology. Students appreciate such 'story telling' as they seem to identify with clinicians more readily than with social scientists.

The course also includes a six-hour interviewing practical during which students in small groups interview patients and discuss communication skills. They are excited about visiting a clinical department, and are often as embarrassed as amused by teachers' feedbacks as they watch their awkward behaviours on the video monitor. That 'crazy' psychiatric patients can talk sensibly invariably makes a powerful impression on them. The whole exercise involves 120 teaching hours and is highly rated by students, one of whom wrote:

> "I felt that the practical is a golden chance for us to interact with patients in the preclinical years. Minor things that we usually neglect, such as greeting the patient politely, arranging the chairs, and using open ended questions, are in fact very important in doctor-patient communication or even everyday social interactions. It is exciting to see the faces of my classmates and myself on the monitor. There are so many awkward facial expressions and gestures to correct! After this practical, I have a much deeper understanding of the saying–to cure sometimes, to relieve often, and comfort always. I also learn that being a doctor does not merely mean book knowledge since medicine is a humanely conducted science."

We believe that a behavioural sciences course run by competent psychiatrists who continue to be keen to teach is an under-recognised source of enhancing students' attitudes towards psychiatric medicine.

SING LEE and CHAR-NIE CHEN, *The Chinese University of Hong Kong, 11/F, Prince of Wales Hospital, Shatin, Hong Kong*

Validity of oral consent

Sir: I refer to the interesting case posed by Dr Alfred C. White (*Psychiatric Bulletin*, 1994, **18**, 507). I think the patient gave express consent in the form of oral consent which is legally as effective as written consent although obviously subjected to uncertainties. He willingly accepted ECT and thus gave implied consent. The consultant psychiatrist was satisfied that the patient understood the purpose, nature and consequences of the treatment offered. He appeared to have given sufficient information about ECT and the risks involved to satisfy the 'Bolam Test' (Bolam v Frien HMC 1957). Under the circumstances described I think oral consent was acceptable. I would suggest detailed records to be kept and a phone call made to the hospital's solicitors to confirm that the oral consent was valid.

S. E. GOH, *All Saints Hospital, Winson Green, Birmingham B18 5SD*

The Christopher Clunis enquiry

Sir: Jeremy Coid (*Psychiatric Bulletin*, 1994, **18**, 449–452) raised concerns about the ability of community services to protect the public from dangers associated with mental illness. However, I fear Coid has misinterpreted the main issue. He surmises, "The main importance of the Christopher Clunis enquiry is that it now poses very unpleasant questions about the ideology of health care delivery and the *routine clinical management of severely mentally ill persons* in the UK." (my emphasis). If I were a severely mentally ill person I would take great offence at his reasoning. The majority of severely ill patients are not dangerous. Dangerousness is not a feature associated solely with severity of illness. Some of the most dangerous patients I have dealt with are mild to moderately ill and of course the courts see many others who are not ill at all. The focus of concern should be how to manage those who (a) are chronically and intractably severely mentally ill and (b) have long-term problems with serious violence (as reflected in past serious acts of Clunis).

The main problems I have encountered in the community management of this group are:

(a) it does not take too long for clinicians to amass a worrying number of patients who may not only attack others but clinicians themselves. This erodes job morale

https://doi.org/10.1192/pb.19.1.53-a Published online by Cambridge University Press

(b) short term in-patient care if not conducted by the community clinician often ends with discharge by a hospital with an unrealistic community aftercare plan
(c) patient mobility as in the Clunis case may invalidate management plans
(d) staff security in a community setting is more of a problem than in hospital. When violence erupts in a community setting be it in a home or a clinic there tends not to be the backup that hospitals enjoy. I learnt this the hard way – fortunately despite a severe beating no permanent damage was done – unlike a social work colleague who was shot.

The issue must be focused on the minority of severely mentally ill who in addition behave violently. I see management of very severely mentally ill non-violent persons in the community as quite achievable. However, asylums are needed for those posing major threats to others. Let's not confuse the two.

CHRIS CANTOR, *76/101 Wickham Terrace, Brisbane, Queensland 4000, Australia*

Requirement of knowledge of local mental health acts in the membership examination

Sir: I would like to congratulate Jeremy Coid on his editorial concerning the Christopher Clunis enquiry (*Psychiatric Bulletin*, 1994, *18*, 449–452). However, almost as an aside, his article does contain one important inaccuracy, which if not corrected could have serious consequences for MRCPsych examination candidates. He says on p.450 "Examination of psychiatrists for membership of the College does not include the Mental Health Act at the present time." This statement is wrong. First, the peoples of the British Isles (the main constituency for the College examination) are served by psychiatrists in four different jurisdictions and there are four mental health acts. The College membership examination part II examines candidates in any of the four acts dependent on the jurisdiction in which the candidate has been working. Candidates can expect to answer questions about the appropriate act for their jurisdiction in either the clinical examination or the oral examination. There is one qualification of this point, and that is that the examiner also has to be familiar with and working in the same jurisdiction as the candidate.

What I believe has misled Dr Coid, and others on occasions, is that the Examination Committee has, for the time being, abandoned any attempt to introduce questions about these four different pieces of legislation into the MCQ, the SAQ, or the essay papers. This is simply due to the difficulty of setting questions which are fair to all candidates and questions which can be marked by all examiners.

There is also a further misunderstanding, from some quarters outside the College, about the responsibility for checking that psychiatrists are familiar with the mental health act they have to operate. This responsibility lies clearly with the Secretary of State for the Mental Health Act (1993), and a health board for the Mental Health (Scotland) Act 1984. It is sometimes wrongly assumed by health authorities in England and Wales, and health boards in Scotland, that doctors who have the MRCPsych qualification are necessarily conversant with the local jurisdiction. It should be obvious that this is not necessarily so; psychiatrists trained in one jurisdiction can, and do, move to another. It follows logically that health authorities and health boards in England, Wales and Scotland, should pursue other methods of scrutiny for this purpose.

I hope this makes a constantly misunderstood situation slightly clearer, and in particular I hope it will prevent any potential candidates for our examination from assuming they do not require knowledge about their local mental health act; they do.

JOHN GUNN, *Deputy Chief Examiner, Royal College of Psychiatrists*

Advice from a paranoid psychiatrist

Sir: As psychiatrists we are becoming increasingly sensitive to the repercussions that may occur should one of our patients seriously injure himself or others. This may be particularly prevalent in forensic psychiatry where the difficulties and dangers associated with forensic patients have the capacity to induce a paranoid and cynical approach in the clinical practitioner. This can lead to a

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