Reply

DEAR SIRS

I am grateful to Dr Weich for the comments he raises about the important issue of supervision which I did not have the space to address in the article. However, as it has rightly been raised, I would like to make a few comments.

It was sensitive of Dr Weich to pick up the sense of feeling somewhat alone in trying to struggle with the dynamics in out-patient work. In the unit where I worked at the time (an average NHS psychiatric hospital in Surrey) dynamic supervision was available, but dealt with patients undergoing formal psychotherapy. Out-patient work was supervised, but limited by time constraints and a medical model orientation. I was fortunate in that a weekly psychotherapy interest group was held where broader clinical issues were examined, including out-patient work. The group provided me with much support and opportunity to reflect with others, but was autonomous to my training programme. I agree with Dr Weich that unsupervised work can lead to dangerous and pathological acting out, although to ignore events occurring within the doctor patient relationship can also lead to disastrous results.

The issue of how to integrate our work with different models kept separate in clinical practice remains unresolved within the current general psychiatric set up, and within trainees' training programmes. I hope that bringing attention to these difficulties can further stimulate thought and action aimed at resolving them.

S. TIMIMI

Westminster Children's Hospital
Udall Street, London SW1

Patients repeatedly admitted to psychiatric wards

DEAR SIRS

Drs Evans, Rice and Routh (Psychiatric Bulletin, June 1992, **16**, 327–328) make the same clinical error that I have had cause to write about twice in the past six months (Cohen 1991, 1992). In the patients they describe it is not possible to make a diagnosis until some days *after* the alcohol and/or drug has been stopped and in the vast majority of such patients the diagnosis is not schizophrenia or manic depressive psychosis. All too often the diagnosis is made and treatment begun by junior doctors on admission when the history of the taking of alcohol/drugs should have compelled a waiting policy; attention to organic features in the mental state at this stage, quite apart form the history, would sometimes give a clear indication of the true nature of mental disturbance and this part of the mental state examination in such patients is often inadequately recorded.

Such patients need to be confronted with the fact that they have a choice – if they stop taking their substance their very unpleasant experiences will cease, if they don't they won't. Neuroleptic drugs do not work in these circumstances as the authors discovered and to give them is to pretend that the patients have an "illness" for which "treatment" can be given instead of symptoms caused by the substances that they are taking. This is a recipe for failure of management as the authors describe, as it *prevents* correct management. Neuroleptic drugs should not be prescribed and after-care should be appropriate to alcohol/drug abuse. Where the latter is refused the only thing that can or should be offered is first aid to protect the patient and others. Why, for instance, did one of their patients have to discharge himself on four occasions against medical advice when he is said have used alcohol and drugs on the ward and should probably have been discharged forthwith?

The problem described is sadly common and represents an enormous waste of resources. Perhaps it is time the College tackled it on a national basis.

SAMUEL I. COHEN

8 Linnell Drive
London NW11 7LT

References

COHEN, S. I. (1991) Cannabis psychosis, *Psychiatric Bulletin*, **15**, 706.

—— (1992) "Black" issues in mental health practice: Cannabis psychosis: *Psychiatric Bulletin*, **16**, 513.

Reply

DEAR SIRS

Professor Cohen makes a valid point about the difficulties in differentiating between drug induced and functional psychoses. However this does not apply to two of the three revolving door patients described, nor do I agree with his suggested treatment for the third.

Patient 1 was diagnosed as schizophrenic in his middle teens and as a chronic schizophrenic with persistent auditory hallucinations and paranoid delusions in his late teens. Initial compliance with medication did not help his symptoms, nor did psychological treatment. It is not therefore surprising that, in common with his peer group of unemployed young men in "bedsit land" he uses illicit drugs. The exacerbations in his mental state probably are caused by his drug abuse, but I do not think he should be rejected by health services for refusing to comply with a partially effective treatment with, to him, worse side effects than his symptoms.

Patient 2 abuses alcohol when hypomanic as a symptom of his illness. He does not abuse it when depressed or euthymic.

Patient 3 has the differential diagnosis of drug induced psychosis at every admission and probably fits into the category described by Professor Cohen. Neuroleptic medication is usually prescribed symptomatically on admission and is effective in reducing psychotic features and behavioural disturbances. I know of no general psychiatric facility which could cope with acutely psychotic young men without some form of chemical sedation. It would be a misuse of the forensic service even if they could handle the numbers involved.

Most drug abusers tend to "mature out" from drug abuse over a period of up to ten years. This provides the rationale for maintenance treatment of addicts, keeping them as healthy as possible, out of trouble with police, and in contact with a trusted psychiatric service for when they are willing to accept help. Surely the drug abuser who becomes psychotic is most in need of this continuing support?

MAVIS EVANS

Wirral Hospital
Bebington, Wirral
Merseyside L63 4JY

Research accreditation of seniors?

DEAR SIRS

We read with interest the report by Bartlett and Drummond (*Psychiatric Bulletin* June 1992, **16,** 361–362) concerning the difficulties one of their registrars had with a research project of theirs. One of us (Kerwin, 1992) recently made a plea for proper research training of consultants before they are allowed to supervise juniors. This was a somewhat tongue in cheek letter (tit for tat for the "T" psych accreditation for clinical academics) but clearly this case highlights the need for ensuring that consultants should also be properly trained to supervise research.

Registrar research need not be difficult so long as consultants ensure success by advising on parsimonious and achievable studies. Drs Bartlett and Drummond asked their hapless registrar to perform a "... randomised double blind, double dummy, parallel group comparison of trazodone and clomipramine as an adjunct to behaviour therapy in the treatment of non depressed subjects with primary obsessive compulsive disorder!"

Maybe we really should insist on research accreditation of seniors?

R. KERWIN
L. S. PILOWSKY

Institute of Psychiatry
De Crespigny Park
London SE5 8AF

Reference

KERWIN, R. (1992) Raw deal for academics, *British Medical Journal* **304,** 1058

Reply

DEAR SIRS

We would like to thank Drs Kerwin and Pilowsky for their interest in our article. Regrettably, they appear to have misunderstood our purpose and, equally regrettably, to have resorted to an implicit attack on our research credentials. We will not address the second of these two criticisms. However, we would like to emphasise that in practice research can be hampered by problems, both within and outside the researcher's control. Registrars, at an early stage of a research career, are particularly vulnerable to such difficulties, even when appropriately supervised by experienced senior academics. Furthermore, the writing up of research within the style favoured by the 'medical model' encourages authors to be less than frank about the practical aspects of research and to disguise deficiencies in their 'end product'. We have 'come out' about the reality behind much of this type of research.

A. E. A. BARTLETT
L. M. DRUMMOND

St George's Hospital Medical School
Cranmer Terrace
London SW17 0RE

Overseas doctors – training ethos

I have been closely following the correspondence pertaining to overseas doctors and their training requirements. Each author (Matthew, O'Dwyer, Zaffar, Gandhi) and the Royal College of Psychiatrists (*Psychiatric Bulletin*, 1991, **15,** 699–700; 1992, **16,** 231–232; 1992, **16,** 446–447) has made pertinent points.

The arguments are self-fulfilling towards a distinct symbiotic relationship between overseas doctors and the NHS of the UK. The majority of overseas doctors are keen to work in the UK for a British degree, and in return the NHS fulfils its manpower requirements, thus serving the philosophy of *Achieving a Balance*. The NHS is a beneficiary of highly motivated and well-qualified manpower obtained through the Overseas Doctors Training Scheme. 'Overseas doctors' are in the prime of their youth, trained at the expense of the developing world, contributing their share to the national exchequer by paying taxes and National Insurance contributions. An 'overseas doctor' is offered a training post which helps fulfil the statutory requirements needed to obtain a higher British qualification in psychiatry, which is a powerful tool to face stiff