Rossini; most music lovers would reach for their *Grove* and confirm that Rossini's operatic output proceeded relatively undiminished long past his twentieth year, up until 1829 when he produced his last opera *William Tell*. Rossini, at the age of 37 years (born 29 February 1792), then went into a creative decline, although he did write his *Stabat Mater* in 1832 which may reflect a growing melancholia at that time. In 1864 he wrote his *Petite Messe Solennelle*, bringing an essentially non-productive period of 32 years to an end, but whether this was due to "the longest mood swing on record" is speculation of the best quality! During this period his wife died (1845) and yet he remarried just two years later. A wealthy man, he hosted superb gourmet dinner parties for eminent musical friends and literati and does not appear to have been particularly depressed during this period. However, a certain instability and laziness of character is recognised, alongside an emotional lability stirred up by nationalistic feelings and a degree of jealousy for the rising popularity of other composers and can be cited as antecedents for depression.

My studies lead me to conclude that Rousseau most likely had an episodic bipolar affective disorder, not 'madness' (schizophrenia), and most of his creative output occurred between episodes. In this respect, I cannot accept him as 'undeniably mad'. I have only confidently identified 15 cases of schizophrenia/paranoid psychosis among creative writers, and most were poets.

Having a personal interest in the psychopathology of eminent deceased persons with extensive data gathered on some 550 famous individuals, I would like to echo the points made by Mezey concerning suicide among major writers. Of 140 eminent creative writers in my series, 56 committed suicide – some 40%, of whom 50 had major psychiatric disorder (mostly affective disorders but a few schizophrenics), two a primary diagnosis of alcohol/drug dependency, and four uncertain psychiatric disorder. Only three of the 50 with major psychiatric disorder had an associated alcohol/drug dependency, which runs counter to expectation.

I would agree with Mezey's principal message in that a detailed knowledge of a writer's psychopathology "cannot *explain* the nature and origin of poetic gifts", but I would go further and say that an understanding of a writer's psychopathology, the emotional tensions and the personality factors colouring the clinical picture, facilitates a better appreciation of both the writer and his/her creative works.

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Consultant manpower (1)

Sir: Regarding severe shortage of consultant psychiatrists, Dr Jarrett's suggestion of increasing the period of permit free training for overseas doctors will not be acceptable to the General Medical Council (GMC) or the Home Office (*Psychiatric Bulletin*, September 1995, **19**, 573–574). In any case, this is unlikely to work as the bottle-neck between registrar and senior registrar posts persists. An increase in manpower approval of senior registrar posts has not worked and is unlikely to be successful in the present economic climate. Also, it will take several years to make a significant impact in reducing consultant shortages.

'Rehabilitation' of 'inadequately trained' psychiatrists may be the only solution in the present circumstances. Many hospitals and Trusts have no choice but to employ such psychiatrists. Certainly it is better to have someone to provide a service than none at all. Many locum consultants are in post for years and have extensive experience, far greater than a new 'adequately' trained consultant. Dr Jarrett is correct in pointing out that the proposal of rehabilitation of such doctors will be resisted by the College and Department of Health but I am not certain what Professor Thompson means by "We can but try". In fact the College itself has used double standards. On one hand, it threatens health authorities and Trusts with refusal to grant approval of such consultants as an educational supervisor and, at the same time, in its Guidance for College Assessors on Advisory Appointments Committees, states that the consultants (inadequately trained) would be able to apply to the College, after not less than one year as working as a consultant, to become an educational supervisor. The College also says that it would be unable to recommend to the GMC that the candidate's name be placed on the specialist 'T' register, yet the College has granted TPsych registration to many inadequately trained consultants. This makes me wonder what this TPsych actually stands for. If these inadequately trained consultants with TPsych apply for another substantive post, would College assessors consider them adequately trained?

The problem of inadequately trained and locum consultants is not a recent one. Azuonye (1990) suggested that locum consultants in continuous employment for four years should be considered for an appointment to a substantive consultant post. I must say a great deal of the problem lies with the College itself in that it has failed to give appropriate advice through its Manpower Committee to the Department of Health, Health Authorities and Trusts as to how to deal with

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the consultant manpower crisis. An increase in senior registrar posts is not the only answer.

AZUONYE, I. O. (1990) Qualifications for appointments to substantive consultant posts. *Psychiatric Bulletin*, **14**, 565–566.

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Sir: Dr Kumar's pessimism about increasing the period of permit free training (i.e. on a post-graduate doctor's visa) is unjustified. I have recently been told by the NHS Executive that permit free training can be extended to six years on the advice of the local postgraduate Dean (see EL(94)37). With this period of training completed a doctor is eligible for a consultant post. According to the Executive, even non-EEC doctors can be given work permits for consultant posts, on the application of an employer, if no suitable UK or EEC doctor is available, presumably notwithstanding the wishes of their sponsors.

The apparent inconsistency in the College's recommendation of doctors for the 'T' Psych, Dr Kumar's second major point, results from the College providing 'rehabilitation' of nearly accreditable consultant psychiatrists. But, there is still a further need for rehabilitation. In correspondence the President of the College has told me that the Chairman of the Joint Committee on Higher Psychiatric Training (JCHPT) is to propose such a system. We eagerly await such proposals because of the urgency of the manpower crisis.

Dr Kumar's letter, and those of Drs Storer and Thompson (*Psychiatric Bulletin*, September 1995, **19**, 573–574) illustrate how any discussion of consultant manpower comes back repeatedly to the issue of insufficient funded senior registrar posts. This under-funding is due neither to the caprice of employers nor simply to lack of money. Certain features of senior registrar posts make it preferable to employ junior doctors, or nurses or others instead: the posts are expensive; provide at best four days, but sometimes only three days of clinical service per week; cannot be used to base the service around since the training needs for the next postholder may not include that service; are supposed to be supernumerary and not stand-ins for the absent consultant; and require supervision from the consultant. These objections are no doubt well understood by the JCHPT but until they are seen to be met many districts will be unwilling to fund senior registrar posts.

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Sir: Dr Kumar raises a number of points in his letter which are unsubstantiated.

First, we have been made aware of only one case in which a non-consultant has been awarded the TPsych without having had an appropriate amount of senior registrar training. If Dr Kumar knows of others (he refers to 'many inadequately trained consultants') we would of course wish to know about them.

He also refers to the College using 'double standards' but it is unclear to what he refers. The College does indeed insist that three years of training as a senior registrar is necessary before appointment to the consultant grade, and that candidates who have not achieved this minimum criterion (four is preferable) should be deemed to be inadequately trained by the College. The sanction which we can apply is relatively minor considering that we have a responsibility to the public to guard the standards of psychiatric services in this country. I doubt that there would be many people who use psychiatric services, who would accept that less than three years of specialist training is sufficient to turn out an adequately trained consultant psychiatrist with all the range of responsibilities that falls to them.

Finally, Dr Kumar dismisses the efforts made by this College to convince the Department of Health of the need for greater manpower in psychiatry, particularly at consultant level. He suggests that increasing senior registrar numbers is not the only way to deal with this, but he seems to offer no viable alternative solution. Perhaps he would like to correspond with the Chairman of the Manpower Committee, Dr David Storer, if he has ideas which College Officers and Manpower Committee members, have overlooked in their detailed scrutiny of this problem over the last decade or so.

In my response to a previous letter I used the phrase 'we can but try' to refer to efforts which we are currently making to identify viable means by which long-term locum consultants, can re-enter realistic periods of training before being identified as substantive consultants (see also The College section, p. 252).

There are considerable difficulties with this proposal and if Dr Kumar has any helpful suggestions which may simplify our deliberations, he is of course, welcome to write to me, the Chairman of the JCHPT, or the President with his views. This would receive a good deal less publicity than a letter to the *Bulletin* but it may be more effective.

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