perception of what the Defence Unions would and would not do. At no point do we suggest that we believe that this is what the Defence Unions would or would not do. But we do indicate our dismay at responses we have had from the Defence Unions hitherto.

Mr Panting's rephrasing of the standard Defence Union response comes somewhat closer to being helpful in our opinion. He states that "broadly speaking, provided there is supportive expert opinion, then the claim will be defensible, irrespective of the wording of the drug licence". We realise that on the one hand that the whole field of medicine may be driven to an extraordinary extent by fashions and fads that have little evidence base and against this background the job of a Defence Union may be particularly difficult. We were drawing attention, however, to the hazards of relying on a supposed evidence base that underpins product licensing as a defence against members or insurers finding themselves in difficult situations. It might, perhaps, be too much to ask Defence Unions to provide an ideal response to enquiries, which would be that they are in the business of supporting physicians to do all they can for their patients.

Reference

HEALY, D. & NUTT, D. (1998) Prescriptions, licences and evidence. *Psychiatric Bulletin*, **22**, 680–684.

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Standards of statistical presentation in the *Psychiatric Bulletin*

Sir: We were interested to read Brown's description of substance misuse habits and staff perception of them in a chronic psychosis sample (*Psychiatric Bulletin*, October 1998, **23**, 595–597), particularly the main finding that staff had a significant tendency to overestimate the rate of substance use.

We were, however, concerned about the standard of presentation of statistical findings in this paper on a number of accounts which we would like the authors to address.

In Table 3, showing the logistic regression results it was unacceptable that no correlations were presented either in the table or in the text and that the results were only presented as odds ratios. In particular it is regrettable that the odds ratio for 'living independently' as a risk factor for substance misuse was stated to be: 1.54 with 95% confidence limits of 1.01–1.32, an obvious error, we hope typographical in origin.

We are left confused about the direction of the effect which the authors describe as being one of the main findings of the study – that is, the contribution of the risk factor 'younger age' to substance misuse in this group. Whereas Table 3 describes the logistic regression data as showing younger age as a factor suggesting marginally, but non-significantly reduced risk of substance misuse (odds ratio of 0.97 with 95% confidence limits of 0.95–0.98, exhibiting a similar error to that above), the text states that the regression results are in the opposite direction, though does not detail them.

While a minor point compared to the above, we regret that in Table 2 contrasting patient reports and staff perceptions of substance misuse by χ^2 analysis, the *P* values are stated, but actual values of χ^2 are absent from both the table and text.

It appears that this paper illustrates some fairly basic errors of statistical presentation and it seems regrettable that they were not spotted pre-publication as part of the review process.

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Sir: I am grateful to Drs Ogilvie and Sircar for allowing me the opportunity to correct the statistical errors in this paper.

Substance misuse was correlated with younger age and with living independently. The odds ratio for independent living as a factor for substance misuse was 1.32 (95% CI 1.01–1.54). The first error was a misguided attempt to clarify the data presented in the table, the second typographical. In both cases *mea culpa*. As to the form in which logistic regression results were presented, this was as requested by the *Psychiatric Bulletin*.

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Additional clinical load as a cause of stress

Sir: I read with interest the article by Guthrie *et al* on Sources of stress, psychological distress and burn-out in psychiatrists (*Psychiatric Bulletin*, April 1999, **23**, 207–212). I was amazed to find no mention of additional clinical load being a cause of stress and burn-out. Such work is

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carried out for prolonged periods as a result of consultant vacancies which are difficult to fill substantively, or often because trusts are reluctant to fill such posts with locum staff, since they see the opportunity to make financial savings. Similarly, prolonged sick leave absences are not being covered by locums since trusts, certainly in my own personal experience, are reluctant to spend the money required. It might be interesting to do a survey of all trusts providing mental health services, to find out how many vacancies are currently being covered by locums and how many trusts just expect their consultant psychiatrists to carry additional clinical workload without of course any financial recognition of this.

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Pre-registration posts in Sheffield

Sir: We were intrigued to read the article by Thompson & Sims (*Psychiatric Bulletin*, April 1999, **23**, 227–229) which presciently suggested the introduction of pre-registration posts in psychiatry as a means of enhancing the number of doctors practising psychiatry. We would have been happier if acknowledgement of the fact that such a scheme had been in existence in Sheffield since 1991 had been included. Certainly, Professor Sims, when President, was a warm supporter of the scheme and tried to introduce it in Leeds.

The prescience comes in because a review of the cohort of doctors is about to appear in the *Bulletin* and demonstrates the value of this scheme in bringing in psychiatrists, and equally important, ensures that those who became general practitioners have specific experience of psychiatric practice. This can be no bad thing for their patients.

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