cation of the disorders which they are studying and who have access to a large data-base of patients. If psychiatrists isolate themselves in the community, progress in the understanding of the neurobiology of psychiatric illness will surely be delayed

PAULA H. SALMONS

Burton Road Hospital
Dudley, West Midlands

A career in psychiatry

DEAR SIRS

It is always flattering for an author to be mistaken for one of his characters but Dr Harrington (*Bulletin*, May 1988, **12**, 169–174), has given your readers the impression that their current President as early as 1973 had come to the "harsh conclusion that though psychiatry offers a fascinating and rewarding career, in the future it may be impossible to practise it properly because of lack of staff and resources".

He is quoting from a contribution which I made to a symposium on 'Planning a District Psychiatric Service'.[1] My topic was 'Manpower' and I discussed the possible roles and functions of the consultant – "the ghost in the machine". I contrasted various views of what was desirable as psychiatric manpower with what was actually available at that time. One particular Committee, to which the College contributed, asked for numbers of staff which seemed quite unobtainable. "My" gloomy conclusion was put into the mouth of someone who demanded this lavish staffing as essential. I went on to say "if we accept the harsh realities which I have outlined, what is a psychiatrist's job description and how do we train people for it?"

Interested readers can look this up for themselves. However, Dr Harrington is partly correct: I do believe that psychiatry offers a fascinating and rewarding career.

J. L. T. BIRLEY
President

Reference

[1]BIRLEY, J. L. T. (1973) The ghost in the machine. In *Policy for Action* (eds. R. Cawley & G. McLachlan). Nuffield Provincial Hospitals Trust, Oxford University Press.

Research as a registrar

DEAR SIRS

Competition for senior registrar posts is becoming increasingly intense in psychiatry, although not as tough as in other specialities such as general medicine and surgery. It seems that the MRCPsych is no longer a passport to a senior registrar post and, when competing for jobs, it is wise to have as many point-scoring attributes as possible. From my own experience, research experience and, better still, publications of some form, seems almost a necessity now and interviewers have realised that just "having a protocol" ready does not always mean that this will result in the work and effort needed to produce a publication.

Having worked in both a non-teaching, country-situated asylum and a teaching hospital, I have found that trying to get myself involved in some form of research can be quite easy in a teaching hospital where there are consultants who are already involved in projects and enthusiastic in giving advice and ideas to willing registrars. I think that as well as being in the right place, being lucky and working for the right person helps. Some seniors teach and give advice and help that proves to be invaluable in later years but I feel that there should be more emphasis on the teaching of research methodology in the preliminary exam and also the membership (now Part II) so that senior house officers and registrars in psychiatry can be "research minded" at an early stage in their careers and not when they are buying a new suit for an interview!

Finally, mammoth projects demand mammoth amounts of time and effort and a realistic project with clearly defined goals and limits would be wise for a busy registrar. Most of us realise that we will not be winning a Nobel Prize in the near future but some of us will progress from the necessity of undertaking research for job hunting to a more serious and demanding approach.

A. MARKANTONAKIS

The Ipswich Hospital
Ipswich

With regard to Dr Markantonakis' letter, research is important for a psychiatric trainee – both to evaluate research and to be involved with research. Research features within the MRCPsych Examination and research methods is recommended to come in MRCPsych courses. The College also organises, and advertises regularly, short courses in research methodology via the College's Research Committee.

Professor A.C.P. SIMS
Dean

Erosion of clinical autonomy of RMOs

DEAR SIRS

Over the last decade considerable changes in the practice of psychiatry have taken place. No more is the consultant accepted as head of the therapeutic programme by the non-medical professions. This has

https://doi.org/10.1192/S014007890002174X Published online by Cambridge University Press

led to confrontations but the matter has not been resolved and is obviously detrimental to patient care. An element of 'democracy' has been introduced in the overall medical care of patients and the doctor has found himself in the minority with his views ignored and often overruled. Although the Responsible Medical Officer, he has been placed in a dilemma by not being able to give the patient the best possible medical treatment. The DHSS has never clarified this matter. This erosion of clinical autonomy is making a mockery of patient care as it gives the doctor responsibility but not authority in the treatment programme.

In the 'long-stay hospital' the situation has become acute, especially in view of the closure programme. No longer are the RMO's views on patients' suitability for transfer or discharge sought. Deficiencies in paramedical services for hospital patients remain unremedied and the doctor's dream of upgrading medical care and treatment remains unfulfilled. Such despair cannot be a good thing for the National Health Service as a whole or the country at large.

U. J. Dey

Brockhall Hospital
Old Langho
Nr Blackburn, Lancs.

Current norm for consultant psychiatrists in mental handicap

Dear Sirs

I am writing to express concern regarding the current norm for consultant psychiatrists in mental handicap (*Bulletin*, April 1988, **12**, 155) and the College's role to influence at Regional level some of the 'overloaded' jobs. The current norm of 1 to 200,000 is at least over a decade old and it was expected that the College would have recommended an improved figure of at least 1 to 100,000 if not better, parallel to other subspecialties of psychiatry. At present in East Dorset (Bournemouth) there are 11 general psychiatrists, two psychogeriatricians and three child psychiatrists against one consultant psychiatrist in mental handicap for a population of 430,000.

I would like to generate a constructive argument about some of the posts having catchment areas of over 650,000. How can one do justice to the services with this sort of catchment area? I am sure that the job descriptions of this kind of post must have gone through for an approval to the Regional Adviser in Psychiatry or the local professor's department. They should either force the Region to improve on the job or refuse to give College support and approval for the job description. In certain districts the job description is changed after approval of the job for advertisement, which I feel should be considered seriously, and the Regions should be advised not to do that and instead re-submit the job description for approval. The College's representative on the Appointment Committees should also look into these factors as the candidates cannot always grasp all information on a preliminary visit and may not be aware of 'grey' areas of the job.

I would suggest the following:

1. change the norm to 1 WTE to 100,000
2. strict screening of job description before approval and advertisement
3. frequent review of the situation
4. if possible to 'blacklist' the Region or District which does not improve the job descriptions or comply with the College guidelines.

G. S. Sarna

East Dorset Mental Handicap Services
Bournemouth

Appropriate use of Sections 2 and 3 of the Mental Health Act 1983

Dear Sirs

In my letter (*Bulletin*, November 1987) I said that I would welcome a statement from the Commissioners on the controversial matter of the appropriate use of Sections 2 and 3 of the Mental Health Act 1983, and that I hoped that their recommendations would be on the lines set out by Dr Aaronricks (*Bulletin*, June 1987). I would therefore like to welcome the letter from the Chairman of the Mental Health Review Tribunals (*Bulletin*, May 1988). As may be surmised from my correspondence, I am totally in agreement with the distinctions made by the Chairman between the appropriate use of Section 2 and Section 3 and if I may be so bold as to speak for Dr Aaronricks, I believe that these were the distinctions that he was also emphasising in his correspondence.

Donald Bermingham

Hinchingbrooke Hospital, Huntingdon
and Fulbourn Hospital, Cambridge

Wider use of benzodiazepines

Dear Sirs

The statement on benzodiazepines which you published in the *Bulletin*, (May 1988, **12**, 205) is quite misleading. It reads as if benzodiazepines are only used as anxiolytics and hypnotics, and ignores the wide potential for the use of benzodiazepines in other areas of medicine. Benzodiazepines are widely used in neurological practice, in particular for their muscle relaxant and also anticonvulsant properties. A number of benzodiazepines are now used routinely in the management of epilepsy, including clonazepam and more recently clobazam. The latter drug, a 1,5

https://doi.org/10.1192/S014007890002174X Published online by Cambridge University Press