terminology creeping into psychiatry led me to survey the opinions of professional colleagues and patients as to their preferences.

They were offered the following options although also encouraged to make their own suggestions and comments.

(a) Patient, client, customer, sufferer or user.
(b) Mental hospital, psychiatric hospital, mental health unit or resource centre.
(c) Mental illness, psychiatric illness or on-going illness.
(d) Nurse, keyworker or care worker.
(e) Drugs, medicines or medication.

Fifty-five out-patients responded with 87% (n=48) preferring to be called patients, 54% (n=30) wished to attend a mental health visit and 47% (n=26) preferred to be described as having a mental illness. Fifty per cent (n=28) wished to be cared for by a nurse and 62% (n=34) took medication.

Alternative suggestions to currently used terms were stress-related illness and nervous complaint. One patient commented that changing terms added confusion and disguised the real purpose of the service.

Only 15 (38%) of 39 general practitioners responded but of these 14 (93%) preferred patient and one response to the term 'client' was "YUK!" Eleven (73%) preferred the term mental health unit, but there was fairly even split between mental illness and psychiatric illness and also nurse and keyworker. Thirteen (86%) preferred the term medication.

One particular comment was the hope that we could get rid of some of the ridiculous politically correct terms that have infected mental health services in recent years.

In-patient staff also responded. Of the 14, eight (57%) preferred the term patient, 13 (92%) mental health unit and 11 (79%) psychiatric illness. There was an even split between nurse and keyworker and 13 (92%) preferred the term medication.

In the current climate of destigmatisation it is important that in introducing new terminology we do not cause greater problems in terms of confusion and discomfort for patients and professionals alike.

CHRISTINE M. TYRIE, *Consultant Psychiatrist, Penrith and Eden Community Hospitals, Bridge Lane, Penrith, Cumbria CA11 8HX*

What is a lecturer?

In clinical medical disciplines lecturers are like senior lecturers and professors and face a three-way split. Traditionally they have contracts which give approximately half of their time to the National Health Service. It is logical to assume that their research and teaching output would be at most half that of non-clinical lecturers. Unfortunately, under the pressure of the Research Assessment Exercise (RAE) many universities regard lecturers as full-time staff who should be as productive as non-clinical lecturers. The problem is compounded because lecturers are also in training posts equivalent to the 'Calman' specialist registrar (SpR). These have strict educational requirements and timetables regulated by the appropriate Higher Specialist Training Committee.

What possible ways are there out of these difficulties? There are at least five options:

(a) Lecturer posts should only be offered to those who already have an established research training, perhaps through a research fellowship. They would come to a lecturer post with the realistic prospect of competitive research awards and potential early publications.
(b) Lecturer posts should be regarded as development posts for those who are intent on an academic career. They should only be filled after a full SpR training and with only two sessions per week clinical commitments. This happens now in some medical specialities.
(c) Posts are created which combine academic responsibility, especially to conduct clinical research, with clinical work but are only filled by those with approved research plans as currently occur with Research Council funded posts.
(d) The 'three-way' split of time between teaching, clinical work and research is accepted as unworkable and incompatible with higher training. It is reduced to a two-way split by designation of some posts as teaching/clinical and others as research/clinical.
(e) Some lecturer posts are re-designated as honorary 'academic' SpR posts, and thus removed from the university payroll and the RAE.

Each of these options may be appropriate in certain circumstances. Each has its own balance of benefits and problems. These may be resolved if those in the Royal Colleges who are responsible for maintaining training standards and those in the universities who are responsible for teaching and research work together to develop, consider and implement workable solutions. Clinical lecturer posts should not be allowed to atrophy by neglect.

JOHN WATTIS, *Medical Director,* LAWRENCE WHALLEY *and* PETER TYRER, *Leeds Community and Mental Health Services, The Mansion, Meanwood Park Hospital, Tongue Lane, Leeds LS6 4QB*

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