about 800 chronic psychiatric patients in hospital, mostly schizophrenic. About 200 of them are acutely psychotic and those in remissions also need prolonged pharmacologic treatment.

We currently lack most antipsychotic drugs, some not available now in Croatia, and others too expensive for our limited funds. So, we are short of neuroleptic drugs, antiparkinsonians and benzodiazepines.

In better times we mostly used haloperidol, flufenazine, clozapine, promazine, chlorpromazine, thioridazin, carbamazepine, levamepromazine, buperidine, triheksifenidil, diazepam, nitrazepam, flurazepam, lorazepam.

If you are able to help us in any way we would appreciate it very much.

We hope to hear from you soon.

SANJA MARTIĆ-BIOČINA
JOŠKO VULETIN

Neuropsychiatric Hospital
"Dr Ivan Barbot"
41317 Popovaca
Croatia

The reliability of delivery of interim discharge slips by psychiatric patients

DEAR SIRS

Kerr (1990) expressed doubts about the reliability of the psychiatric patient as a messenger for communication between the hospital and the family doctor. A comprehensive study has been carried out on medical patients comparing the reliability and speed of arrival of interim discharge slips sent by hand and by post (Sandler & Mitchell, 1987). They found that 97% of the slips in both groups arrived, and that 55% of the by hand group arrived within one day. No such work has been carried out on psychiatric patients.

I took 50 consecutive discharges from an acute admission ward. Each acted as his or her own control having a by hand and a by post slip. The slip contained information as to the nature of the admission, follow-up arrangements and the medication on discharge. The doctors' surgeries were contacted by telephone to determine arrival of the slips.

Ninety-eight per cent of the slips sent by post arrived compared with 66% of those sent by hand. Of the 32 pairs, where both arrived, a Wilcoxon Rank Sign test was statistically significant at $P<0.01$. The by post group had a median delivery time of four days compared with one day for the by hand group. There was no significant difference between diagnostic groupings or when Caucasians were compared with Asians.

The posted interim slips therefore arrived more reliably but slower compared with those sent by hand. As the quantity of tablets for a patient to take home gets smaller and the cost of postage rises, I felt it was important to know the reliability of delivery of discharge slips in psychiatric patients. The reluctance to tell the general practitioner of the psychiatric admission may be due to the perceived stigma of mental illness or to lack of insight as part of the illness.

Ideally each patient should have both a by hand and a by post slip (the former ensuring that the latter is written before the patient leaves the hospital). A triplicated pad would allow a record also to be kept in the notes. Where there is only one interim slip this should be posted to ensure reliable delivery. This may lead to practice being changed in some hospitals.

ANN K. STANLEY

Reaside Clinic
Bristol Road South, Birmingham B45

References

KERR, M. S. D. (1990) Psychiatric discharge summaries. *British Medical Journal*, **300**, 260–261.

SANDLER, D. A. & MITCHELL, J. R. A. (1987) Interim discharge summaries how are they best delivered to general practitioners? *British Medical Journal*, **295**, 1523–1525.

Junior doctor representation

DEAR SIRS

At the end of the article 'Working for Trainees' (*Psychiatric Bulletin*, February 1993, **17**, 98–99), the authors' state that they are aware of at least one other active organised junior psychiatric trainee group working at a regional level. Such a group has been set up in South West Thames, with very active trainee participation.

The St George's professional scheme comprises four registrar rotations and two central SHO rotations, which together account for approximately 90 trainees. Each hospital on the scheme has its own local representative, and each of the SHO or registrar rotations has an elected representative. There is a chairman who is elected by all members of the rotation, and represents trainees' views at regional level.

The corner-stone of representation is the two-monthly junior doctors' meeting which is attended by all representatives. St George's Hospital also has a local BMA representative, two trainee members of the Royal College Training Committee and a senior registrar representative. These meetings are a means of conveying problems at local level so that they may be discussed and a possible strategy reached. This organisation has been responsible in part for improving the quality of some of the less desirable jobs on each rotation, and as in Liverpool the trainee criticism seems to have been viewed as constructive by the psychiatric tutors.

The chairman of the committee is able to take matters on board which have not been sorted at a local level. There can be direct communication with the Pan Rotational tutors, and problems can also be taken to the British Post Graduate Medical Federation Meetings, which the chairman attends.

There is also a social side to the activities, with regular rotational meals, generally sponsored by a drug company, and a recent jazz evening, which was open to all trainees and all consultant supervisors on the rotation.

One of the main difficulties encountered in this region is communicating effectively with each trainee. With the mailing list for the junior doctors' committee meetings being approximately 120 individuals, and the lack of designated secretarial support to the committee, this places a great strain on the individuals responsible for mailing. The idea of a newsletter and a logo which is in use in Liverpool seems very useful. However the experience provided to the committee members in administration and working with the every day politics of a training scheme are invaluable. Also the one day introductory course for new SHOs, which the chairman organises twice a year, the review of the end of placement assessment forms and the review of the logbook system used in South West Thames, have been important recent activities.

We would urge the setting up of junior doctor representation at all levels in other parts of the country, as the experience in South West Thames has been extremely profitable both to trainees and to their educational supervisors in improving the overall quality of trainee experience.

TOM MCCLINTOCK
Chairman, Junior Doctors' Committee
St George's Hospital Rotations

A trainee's view of hospital management

DEAR SIRS

The CTC (1990) has stressed the importance of management training for psychiatrists. As a registrar, it seems appropriate to record my impressions of hospital management before they are coloured by formal learning of management theory.

Junior doctors are privileged to occupy a unique niche in the hospital. We are closely involved with a variety of staff on a daily basis, but are not part of their management lines. This permits candid discussion, allowing us to accurately gauge staff feeling. "Manager-bashing" is a popular theme, and although this is hardly a new phenomenon, it is set against a background of low morale, resentment towards the ever-expanding management body, continual complaints of inadequate ward staffing levels, and high rates of staff sickness. Managers tend to be perceived as opponents who do not appreciate their staff, and who are interested only in administration, and not in patient care. Staff often do not feel they can trust their line managers enough to express their opinions honestly. This may or may not be the reality of the situation, but the sentiments themselves are very real.

So where is the system failing, to create such resentment? It appears that hospitals often focus on administrative issues to the exclusion of what must surely be the core of effective management; man management. Many managers seem to take for granted the staff under them. Either the principles of man management are not being adequately taught, or they are being ignored by hard-pressed managers. This must have implications for the training of psychiatrists in this area.

In making these, perhaps naive, generalisations, I myself have fallen into the obvious trap of manager-bashing, but I would stress that this is not aimed at specific individuals or hospitals. I am simply recounting what I and my peers regrettably see in many hospitals, and hope my comments may initiate constructive discussion, if only to prove me wrong. The currency of our business is patient care, and our greatest asset is our staff. If we look after them, surely we stand to gain better value for money in our ever-dwindling budgets?

M. R. ATKINS
Staffordshire

Reference

ROYAL COLLEGE OF PYSCHIATRISTS (1990) The CTC Working Party Report on Management Training. *Psychiatric Bulletin*, **14**, 373–377.

Familial thyroid disorder presenting as folie à deux

DEAR SIRS

I would like to draw your attention to a case of familial thyroid disorder which presented as a folie à deux or induced psychosis. There have been numerous case reports of folie à deux in the literature. The occurrence of psychosis in overactive and underactive thyroid disorders is also well documented.

Case history

Mr X, aged 20, has mild learning difficulties, and lives with his mother and stepfather. The mother and maternal grandfather have hypothyroidism. The mother is clinically myxoedematose. The patient was expelled from special school, aged 14, having threatened a teacher with a knife. He was prevented from leaving the family home by his mother for the ensuing three years. He was first seen by a psychiatrist from the community team for learning difficulties when aged 17.