subjects. It is important to carry out scans in such a way that maximum use can be made of data collected for research purposes ultimately aimed at benefiting the group of those with schizophrenia as a whole.

Currently at Oxford we are carrying out MRI on adolescents presenting with schizophrenia. This group is a good one for testing the neurodevelopmental hypothesis of the aetiology of schizophrenia. The research has been approved by our local Research Ethics Committee.

I would be grateful to be informed of subjects who might be suitable for this study. Only DSM-III R criteria are required. I have obtained a grant sufficient to cover the costs of research scans and travelling expenses. We have scanned 19 subjects so far and aim to carry out two further Saturday morning sessions scanning eight adolescents each time within the next few months.

Please write to me at the address below or telephone 0227 462733.

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An MP questioning clinical judgement

DEAR SIRS

A curious incident happened while I was a senior house officer in old age psychiatry. An 87-year-old lady had been admitted informally to the assessment ward from a residential home. She had been increasingly aggressive and restless, and had threatened to jump out of a window. She had biological features of depression, was not eating or sleeping, had lost a lot of weight, and expressed a wish to end her life.

After admission she remained retarded and there was concern about her fluid intake, amounting to less than a litre over three days. A course of ECT was arranged, and her legal next-of-kin, her daughter, was informed. Subsequently I received two threatening phone calls from her son-in-law, who was a consultant in one of the London teaching hospitals, saying that if we gave his mother-in-law ECT he would institute legal proceedings against myself, my consultant and the health authority.

At this time, the patient's daughter, to the best of my knowledge, had not expressed any reservations about our proposed course of action. When contacted, all she would say was that she needed time to discuss the matter with her husband. That evening I received a phone call from their Member of Parliament stating that he had been informed of his constituents' concern and associating himself with the threat of legal action.

In my two years in psychiatry, I have had instances of relatives being concerned about proposed courses of treatment, but to the best of my knowledge neither I nor any of my colleagues have ever received a phone call from an MP questioning our clinical judgement. I wondered if other readers have had any similar experience.

The patient died from an intestinal obstruction; she had had one session of ECT.

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Involvement in patient care by managerial staff

DEAR SIRS

I read the letter from Ali & Evans (*Psychiatric Bulletin*, 1992, **16**, 661) several times, with some bemusement, and then decided it must be a rather clever and amusing spoof on trends in 'community' psychiatry. That this is so can be seen by substituting *day surgery centre* for day hospital and *wart* for references to anxiety at interviews; the absurdity of the clinical arrangements described can then be clearly seen. However, perhaps I have missed something, or worse, the letter is not a spoof, and there is a real need to be more explicit – with the question, should not interview training of the type described be part of any psychiatric day hospital service when required?

D. M. BOWKER
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Reply

DEAR SIRS

Dr Bowker's analogy of a patient with a wart attending a surgical day hospital is inappropriate. Anxiety at a forthcoming interview was not our patient's presenting complaint; subclinical anorexia nervosa and social phobia were the reasons for referral. The other flaw in the analogy is to assume that a hospital administrator would possess the skills to treat his patient's wart. In fact, our administrator's training and experience in interviewing was the skill employed as an adjunct to treatment.

Our patient's problems were treated over two years with relaxation therapy and anxiety management, supportive psychotherapy aimed at raising self-esteem and assertiveness, as well as art therapy. Only recently during her attendance at our day hospital did the offer of an interview arise, bringing with it associated anxiety. It was due to the initiative shown by the Sister of the psychiatric day hospital who was aware of the administrator's experience, that the mock interviews were arranged.

As to whether this training should have been offered by our staff, not only did our administrator have more expertise in interviewing, but, more importantly, he did not know the patient, thereby being able to simulate the "real" situation more appropriately than if a familiar staff member had undertaken the task. In addition, the interviews took place at a location similar to that for the real interview. Thus we have presented the unusual case where a non-clinically trained NHS manager has been employed in the management of a clinical problem because of his specific expertise. One wonders whether Dr Bowker's response reflects the anxiety some doctors feel when there is debate on the roles of different professions, and the encroachment on our roles as psychiatrists.

IMAD M. ALI

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Sister ANNETTE EVANS

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Patients repeatedly admitted to psychiatric wards

DEAR SIRS

Dr Mavis Evans' reply to my letter (*Psychiatric Bulletin*, 1992, **16**, 664–665) about her article (1992, **16**, 327–328) does not persuade. It is the clinical details and the natural history of the patients, particularly their rapid remission following admission, that shouts a diagnosis of substance abuse as a cause for the disturbed mental state.

Far from saying that patient 1 should be rejected by health services, I said that he should be given the correct treatment for the disorder that he has, namely a drug-related psychosis, and not a spurious treatment which effectively prevents the application of the correct treatment and which in any case is only partially effective. This is so whether or not the original diagnosis of schizophrenia in his teens was correct, and how does she know that it was?

Similarly with patient 2, could the apparent hypomanic behaviour be the result of alcohol? More importantly, Dr Evans does not say how she knows he is not also using cannabis which is probably the commonest cause of mania in young adults nowadays (Rottanburg, 1982).

I am glad that she finds that case 3 "fits in" to what I described. I did not suggest that chemical sedation should not be given; on the contrary, it is frequently necessary as first aid but it is also vital to make a diagnosis and all too often neuroleptic drugs are continued after the first two or three days on the basis of a spurious diagnosis made on admission. Of course, these patients need continual support, but first of all they need the correct diagnosis and treatment and that is the problem that I felt the College needs to tackle with an educational programme.

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References

ROTTANBURG D. *et al* (1982) Cannabis – associated psychosis with hypomanic features. *Lancet, ii,* 1364–1366.

Reply

DEAR SIRS

Professor Cohen argues powerfully for the correct diagnosis and treatment of drug induced psychoses, a course no-one can argue with. However, recurrent (or frequently relapsing) psychoses in young adults existed before widespread drug abuse. Drug abuse in this group of patients can be seen as a symptom of their illness, not an aetiological factor. Drug abuse in this situation needs correct treatment but so does the psychosis itself.

The wider use of screening urine for drugs on admission may help to identify and thus aid treatment in patients where drug abuse is an aetiological, precipitating or maintaining factor. However psychiatry is not an easily measured subject and sometimes we have to take the patient's word on when symptoms appeared in relation to their drug or alcohol usage.

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(This correspondence is now closed – eds.)

'How to get published'

DEAR SIRS

We thought it might be useful to record some of the issues discussed at our senior registrar get-together in September 1992 entitled 'How to Get Published'. The aim of the meeting was to extract practical advice from experts on the topical issue of getting our names into print and so we invited a panel of psychiatrist editors: Professor H. G. Morgan, European Editor Designate *Current Opinion in Psychiatry*; Dr Alan Cockett, Editor of the *British Review of Bulimia and Anorexia Nervosa*; Dr David Nutt, Editor of the *Journal of Psychopharmacology*; and Professor Elaine Murphy, Editor of the *International Journal of Geriatric Psychiatry*. To stimulate thought, senior registrars had been posted in