postgraduate education to ensure that individuals are informed of topical issues, current management and medical procedures. Those who carry out the training should ensure that they themselves are adequately trained. Hospitals are advised to establish policies to cover both physical and verbal abuse. There should also be implementation of a procedure for reporting violent incidents and an audit of these incidents. Employers should carry out a risk assessment and provide staff with adequate training to understand the risks involved and enable them to defuse dangerous situations and only as a last resort to take physical action to deal with violent attacks. Procedures to minimise post-traumatic stress disorder should be instituted by the availability of confidential counselling.

The importance of dealing with violence in order to reduce stress among doctors must not be underestimated. This issue must be taken seriously to protect the most precious resource of the health service—its staff.

SCHNIEDEN, V. & MAGUIRE, J. (1993) *A Report on Violence at Work and its Impact on the Medical Profession within Hospitals and the Community.* BMA North Thames Office. Copies of the report are available from the North Thames Office.

*Correspondence VIVIENNE SCHNIEDEN and JANET MAGUIRE, *Clinical Research Unit for Anxiety Disorders, 299 Forbes Street, Darlinghurst 2010, New South Wales, Australia*

Pro re nata medication: a risk factor for suicide

Sir: We read with interest the paper by Elizabth King (*British Journal of Psychiatry*, 1994, **165**, 658–663) on suicide in the mentally ill. Establishing factors predicting suicide is invaluable. We wish to report an interesting observation.

A near fatal suicide attempt by a schizophrenic patient was preceded by an unusual request for a p.r.n. neuroleptic. Following this a review of p.r.n. medication preceding successful suicides since 1975 in our Special Hospital was undertaken. The case-notes of nine of ten suicides were traced. Six had requested p.r.n. medication prior to their suicidal acts (range four hours to four days). Three of these were regular p.r.n. requesters. The other three had requested p.r.n. neuroleptic medication in the 24 hours prior to committing suicide. In these three patients, the requests were most unusual, these patients not having had any p.r.n. medication for more than six months in two cases and for three months in the third case.

We feel that an unusual demand for p.r.n. medication by a long-stay in-patient may be a sign of increasing patient distress that could predate suicide and may be worthy of objective study.

PRIYADARSHAN JOSHI and J. D. COLLINS, *Ashworth Hospital, Parkbourn, Maghull, Liverpool L31 1HW*

Proposals on continuing medical education (CME)

Sir: Sensky's study (1994) on the experiences and opinions of consultant psychiatrists on CME takes into consideration teaching and attendance at educational meetings. I would like to comment on the latter point.

The assumption that attendance at academic meetings achieves what it purports to accomplish, that is the acquisition of knowledge, may be incorrect. Meetings differ in quality and, unless objective evaluations are carried out, the value of particular meetings may be questionable.

Multiple choice question tests are reliable methods to assess acquired knowledge, easy to administer and to mark with the aid of computers. I propose that speakers and lecturers should prepare a few (say five) MCQs on their topics which would be distributed at the end of the talk. The format should be similar to that used in the MRCPsych examination (i.e. correct, false, and don't know answers). An optimum interval or range of response rate for each item of a question should be agreed in advance to eliminate questions with low discrimination power. To facilitate the analysis, there should be a box to indicate that each particular item in a stem question was known or unknown to the respondent prior to the lecture. A minimum number of respondents or percentage of the audience, or both, should be agreed in advance if results are to be

meaningful. An independent person should do the marking or the questionnaire be sent to the College for analysis.

The questionnaires should be anonymous as the primary intention is to test the usefulness of educational meetings. This will propitiate the participation of professionals. Perhaps those who participate in completing the questionnaire may have a percentage refund as incentive in non local meetings that require a registration fee. For local (free) meetings local practitioners are most interested in making their own meetings useful so I assume that interest in participating will be tacitly present. Although not all meetings should be tested a reasonable number of different types of meetings should take part to permit useful generalisations.

The cooperation of College members is paramount to help obtain the necessary information about educational meetings. The majority of Sensky's sample favoured formal assessment of participation in CME; therefore it seems that there exists an adequate background to support proposals which guarantee some form of objective measurement.

SENSKY, T. (1994) Continuing medical education: consultant psychiatrists' experiences and opinions. *Psychiatric Bulletin*, **18**, 18–21.

DAVID MARCHEVSKY, *Ealing Hospital, Southall, Middlesex UB1 3EU*

Defeat Depression Fun Run, 9 April 1995

Sir: This event really was fun except that fewer than 20 psychiatrists took part. The majority of the 250 runners were patients, nurses, psychologists and paramedics.

The event had been well publicised and was generously sponsored by Smith, Kline & Beecham who also provided drinks, chocolate for the exhausted, marquees and a grand timer clock. The considerable amount of work organising the event was undertaken by Chris Gear and it was both disappointing and disloyal to the College that the psychiatric turnout was so meagre.

Could do better—next year, perhaps?

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Medication levels

Sir: As a schizophrenic patient who has been through the emergency provisions of the health service more than once and is now well integrated into an aftercare programme, I feel I have an angle on the provision of treatment which has not been adequately aired.

It is not difficult for somebody in my position to conclude that the medical profession is used in the psychiatric services as an arm of the state devoted to social control. We are forcibly given overdoses of medication to modify our behaviour such that the fears of carers concerning their perception of threat to ourselves or others are assuaged. In a Machiavellian sense this is understandable, although of considerable inconvenience to us sufferers.

There is another way: I have reached an understanding with my community psychiatric nurse such that I can experiment with the levels of dosage of Depixol which I take, with the result that we have found the minimum dose which works. The advantages of this are enormous; I get negligible side effects and have reached a state which can only be described as mellow. Accompanying this, I get creative, interesting and even fantastic dreams towards the end of the three weekly cycle of medication. The current practice of overkill in the provision of remedial chemicals would seem inappropriate for the needs of many patients.

My purpose in writing is to urge the psychiatric profession to consider more the quality of life of their patients and provide only such medication as will give them minimum abnormality combined with maximum creativity.

Name and address supplied