mental handicap, psychogeriatrics and biological psychiatry); and child psychiatry (including childhood mental handicap).

Although the number of replies was small, the fact that those people who did reply all wrote enthusiastically about the success of these appointments suggests to me that Regional and District Health Authorities should actively explore the creation of linked consultant posts as one way of solving the current manpower crisis in the psychiatry of mental handicap.

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The 'ivory tower' vs the 'poor nation of others'

DEAR SIRS

Although there is much in Dr Nehama's recent article with which I can agree (*Bulletin*, December 1984, **8**, 235–36), his title 'Academic Psychiatry versus Patient Care' implies that there is some necessary antithesis between the two. Dr Nehama argues that 'in some regions' two tiers of psychiatrists are being created. The 'approved and applauded academic élite' (who are preoccupied with teaching and research) and the vast poor nation of others (who undertake patient care). Two pages further on we have Dr Launer writing: 'Back at the ivory tower, the academic side beavers on oblivious to this catastrophe. Large numbers of doctors, psychologists, social workers and nurses in excess of regional norms, and without any extra case loads, remain aloof and busily counting their distinctions according to the number of irrelevant research papers published per year' (*Bulletin*, December 1984, **8**, 237).

As the present incumbent of the ivory tower alluded to by Drs Nehama and Launer, let me assure them that we undertake a very great deal of patient care, and that our

TABLE I
Dr Nehama's hospital and the Ivory Tower

	Prestwich hospital	University hospital of South Manchester
Resources:		
Consultant psychiatrists (WTEs)	13.5	8.2
All medical staff	34.3	32.3
Nurses	379	107
Psychologists	9	15.2
Total 'therapists'	51.8	17
Clinical work:		
Annual admissions	1345	1934
Out-patient attendances	5600	17300
Day hospital attendances	3400	44700

Source: *The Facilities and Services of Mental Illness and Mental Handicap Hospitals in England.* Statistical and Research Reports, No 26 (1984) London: HMSO.

resources compare unfavourably with those devoted to Prestwich Hospital. It is true that our staff carry out a great deal of teaching and research, but it is also true that we undertake a great deal of patient care (see Table I). The very large clinical work load on our Department does not reflect greater use by South Manchester residents of psychiatric services than residents in other areas: it is quite simply because 45 per cent of the patients served by our Unit come from elsewhere in the North-West of England to receive patient care. We are proud, Sirs, of the teaching and research activities of our Unit, and the patients vote with their feet.

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Self-mutilation and Klinefelter's Syndrome

DEAR SIRS

As a researcher in the field of self-mutilation for some 12 years,[1,2,3] I'm puzzled by the recent correspondence by Priest *et al* (*Bulletin*, July 1984, **8**, 140) and Christian, Thomas and Turner (*Bulletin*, November 1984, **8**, 218). It seems to have established, as Christian said, that 'the combination of Klinefelter's Syndrome and self-mutilation does seem to exist'. As there is no reason to suppose that Klinefelter's would lead to immunity from self-mutilation, one has no reason to doubt that the *combination* 'exists'. So do the combinations of self-mutilation with diabetes, ingrowing toe-nails, and a passion for crossword puzzles. We have as yet no reason whatever to regard these occasional combinations as causal or significant. The vast majority of self-mutilators do not have Klinefelter's, and the majority of Klinefelter's do not self-mutilate.

What are we supposed to make of the 'existence' of this occasional, rare combination? How does it help us to understand either condition? Various self-dominating behaviours are relatively common in the general population and probably rather more so in those of dull intelligence. Whereas specific types of self-mutilation are associated with specific genetic anomalies—such as the Lesch-Nyhan Syndrome—no one seems to be proposing that there is any particular relationship between Klinefelter's and any specific type of self-mutilation.

Why are we discussing this combination at all?

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REFERENCES

[1]SIMPSON, M. A. (1975) The phenomenology of self-mutilation in a general hospital setting. *Canadian Psychiatric Association Journal*, **20**, 429–34.

[2]—— (1976) Self-mutilation and suicide. In *Suicidology: Contemporary Developments* (ed. E. S. Shneidman). New York: Grune and Stratton.

[3]—— (1977) Self-mutilation and the borderline-syndrome. *Dynamic Psychiatry*, **10**, 42–48.

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