the issue of South African Psychiatry'. This is unjustified and gratuitously offensive. The College has condemned misuse of psychiatry in the Soviet Union (Quarterly Meeting, November 1978), torture in Northern Ireland (*Bulletin* June 1977, p. 11), and the effects of apartheid in South Africa (*Bulletin* June 1983, **7**, 115). The College pointed out 'that there is substantial evidence that discrimination in the provision of psychiatric services based on race exists in South Africa both in State and Private Hospitals and that this discrimination in the provisions of psychiatric facilities on the grounds of race is to us totally unjust and unacceptable.'

If the Statement by the Society of Psychiatrists proves to be solely 'a cynical attempt to appease Western opinion' (and I hope it is not), then it will be for Dr Sashidharan to show that this is the case. The College's Special Committee on Abuse of Psychiatry can deal only with factual evidence, not opinions. Council has never been involved in 'the endorsement of psychiatric practices in the Republic', as Dr Sashidharan states. It welcomed a statement which positively condemned the ill effects of apartheid. Dr Sashidharan is entitled to promote his views and opinions vigorously. These will carry more weight if he is factually accurate and does not misrepresent the views of Council.

## *Mental Health Act 1983 (Consent to Treatment): A personal view*

DEAR SIRS

The Mental Health Act 1983 ostensibly addresses the issue of consent to treatment, but does little to eradicate the difficulties associated with the treatment of those (severely handicapped) incapable of giving such consent.

Allow me to cite two current cases, which I believe highlight some of the deficiencies associated with Section 58 of the Act. The first concerns a severely handicapped adult (of informal status) in whom dental treatment was advised at a recent case conference. Both the Mental Health Commission and the legal adviser to the Health Authority were unable to furnish definitive advice on whether or not to proceed, although the former were able to confirm my belief that such treatment was in any event outside the scope of the Act.

The second case concerns all those (severely handicapped) residents within the hospital who are receiving long-term oral medication. A recent visit by the Mental Health Act Commission suggested that such residents should be 'sectioned' in order that this treatment may be legally given. This advice in turn raises more questions than answers, most notably: (a) Is it justifiable, or legally correct, to invoke the Act, where it is clear that treatment is proceeding on an informal basis, and without any overt protest or objection (thus negating at least one prerequisite of Section 3)? (b) If the Act were invoked, would this enhance the rights of the individual by ensuring a second opinion (provided for under Section 58) from the Mental Health Commission, or simply result in an otherwise informal patient being unnecessarily 'sectioned'?

It is clear that treating informal patients (incapable of giving informed consent, albeit with the consent of their next of kin) under common law, where a definitive legal position is lacking for either party, is unsatisfactory to both patient and care givers alike.

Although provision is allowed for within the Act for such forms of treatment as may be specified by regulations made by the Secretary of State, the Act as it now stands is insufficiently comprehensive in specific terms to deal with the former issue of dental treatment, or inappropriate in the latter case (of drug treatment exceeding three months).

R. V. BROWNE

*Bryn y Neuadd Hospital*
*Llanfairfechan, Gwynedd*

## *Trainees and research*

DEAR SIRS

In 1980 Dr Helena Waters, then Chairman of the Collegiate Trainees' Committee, surveyed trainees in the Southern Division, at the request of the Executive Committee, to determine the extent of trainee involvement in research. The results of the survey have never been published, but we feel they might usefully be reported in the *Bulletin* as it would interest us to know whether other Divisions have any comparable figures, obtained before or since 1980, which may help to suggest how the situation is developing.

### *The survey*

Four hundred questionnaires were sent to trainees in the Southern Division. Trainees were asked for information about their grade, the hospital in which they were working, their interest in and current involvement in research, and the availability of facilities and supervision for research.

There was a 25 per cent response rate. Replies were received from 16 SHOs, 51 registrars and 28 senior registrars. For the purposes of analysis the trainees were divided into junior trainees (SHOs and registrars) and senior trainees (senior registrars).

The majority of junior trainees (76 per cent) and senior trainees (86 per cent) who completed the questionnaire were based in teaching hospitals. The vast majority (93 per cent) also expressed an interest in undertaking research. At the time of completing the questionnaire, 32 of the 67 junior trainees (48 per cent) and 22 of the 28 senior trainees (79 per cent) were currently engaged in a project.

Junior trainees based in non-teaching hospitals were almost as active in research (44 per cent) as those in teaching hospitals, but this was not so at senior registrar grade where all reporting involvement in research were based at a teaching hospital. Roughly a quarter of both groups were registered for an MPhil or a PhD, and all these were at teaching hospitals.

Fewer junior trainees (39 per cent) than senior trainees (68 per cent) reported that adequate supervision was available, and a small number of trainees (22 per cent of juniors and 4 per cent of seniors) had been unable to arrange supervision when trying to begin a project. Thirty-three per cent of junior trainees and 64 per cent of senior trainees felt that there were adequate research facilities (i.e. access to statistical advice, computers, etc) available to them locally.