

they provide 152 beds for the short- and long-term care of the mentally handicapped in Rotherham, which has a population of 255,000. The Local Authority Social Service has few hostels and group homes which together offer a total of less than five short-term care places. The weekend respite care does a lot of good to parents, but what does it do to the handicapped person, the recipient?

The handicapped person may find himself in a strange ward if the weekend respite has not been booked in advance, or if no bed was available in the usual ward by the time the request is made. He is in on Friday and out on Monday. During this time he would daily have come across, at the least, three different care givers and put up with many other clients, some worse than himself in terms of self-care skills, behaviour and the degree of physical handicap. There is just the time to scrutinize the environment, learn a few of its rules and adapt, and then it is 'goodbye'. The chances are he may have seen no doctor, had no physical examination or a routine clinical investigation. His admission is for a social reason: 'the bed and breakfast use of the hospital', as some call it.

The weekend respite does something to the consultant also. The consultant or the doctor in charge of the Unit is left in a dilemma. In Rotherham, most of these admissions are arranged between the community nurse and parents. Medical secretaries book them in liaison with social workers and community nurses in a few other places I know of. For days after their discharge, the consultant may not know of the clients who have been in for the weekend respite. This is particularly true when there are no junior doctors or when the client is on no medication. Should there be a cause for litigation for negligence during the respite care, or an unidentified diabetic who goes into a coma soon after discharge on Monday morning, who takes the responsibility?

In the above instance, the client was in a hospital and under a consultant, at least, on the HMRI (DHSS Return Form). Should the same happen in a Social Services hostel or in a family home accepting handicapped persons for weekend respite care, the judgement of the public or of a coroner would certainly be different.

There is a need for the transfer of the weekend respite care to selected and willing families. The receiver of the care, by constantly using the same family, may stand to gain more benefits. Well staffed small units in Local Authority Social Service hostels may be a second choice, especially where the degree of handicap is not severe. As for the hospital and hostels, short-term admissions for assessment, treatment, training and other respite should continue to be available for the mentally handicapped.

In terms of cost effectiveness, the suggested transfer may not be cheaper; but the handicapped person will stand to gain, his parents breathing space still assured. But until then, some consultants will continue to live with their dilemma. I would welcome comments from colleagues.

B. N. NWULU

*Beechcroft  
Oakwood  
Moorgate Road, Rotherham*

### *Self-mutilation and Klinefelter's Syndrome*

DEAR SIRS

In his recent letter (*Bulletin*, April 1985, 9, 83), Dr Michael Simpson, writing from Durban, seems to be rather peeved that you are giving space to the correspondence on this subject, to the extent that he asks: 'Why are we discussing this combination at all?'

I presume that he is not really suggesting that you, Sirs, should attempt to censor scientific discussion. My sense is that he is implying that this combination could have arisen by chance. Of course, this is one of the null hypotheses that my colleagues and I would like to test eventually by inferential statistics in the conventional way (Siegel!). However, we are still at the descriptive stage of scientific enquiry, rather than at the hypothesis testing stage.

One of the advantages of having the courtesy of your columns is that we are now able to contact all those who are writing in with further examples. Drs Stawski and Farmer from this department are approaching the correspondents with a systematic list of questions about the characteristics of the patients they have reported. I hope that this revelation will not prevent others from writing in! The answers will then enable us to formulate more precise hypotheses for the statistical analysis.

Your readers could be of assistance in a further way. I am not sure what the exact base rates of prevalence are for Klinefelter's Syndrome, and still less for self-mutilation. If anyone could help us with figures for these frequencies it would help enormously.

R. G. PRIEST

*St Mary's Hospital  
London W2*

#### REFERENCE

SIEGEL, S. (1956) *Nonparametric Statistics for the Behavioral Sciences*. New York: McGraw Hill.

### *Italian psychiatry*

DEAR SIRS

Italy must have a very different pattern of psychiatric disturbance to that in Britain. I assume from Dr Johl's article (*Bulletin*, April 1985, 9, 73-74) that psychosis does not occur, and that until liberated by Law No 180, Italian mental hospitals were entirely filled with unjustifiably detained patients with non-psychotic disturbances. If this was the case, then 'Democratic Psychiatry' with its emphasis on self-determination and its lack of reliance on drugs, is to be welcomed.

I suspect, however, that mental illness occurs in Italy just as frequently as it occurs here. The fallacy exemplified by Dr Johl's article is to treat all forms of psychological disturbance as one and from that premise to argue for a single approach to psychiatric treatment. Dr Johl clearly favours sociological reductionism over biological reductionism, equating the former with democracy, humanitarianism and libertarianism and the latter with professional domination and repression.

Perhaps I am suffering from 'false consciousness' or have been indoctrinated by the medical profession, but I am unable

to find any obvious intellectual superiority in Dr Johl's ideology over that of the 'it's all to do with neurotransmitters' school of thought. It is also worth remembering that demystification, demedicalization, deprofessionalization and dehospitalization are just as much the policies of the Szaszian right as the Marxist left.

STEPHEN WOOD

*Guy's Hospital Medical School  
London SE1*

### **British psychiatrists in Canada**

DEAR SIRs

I read with interest Dr Green's article on British psychiatrists in Canada (*Bulletin*, April 1985, 9, 77-78). He correctly stresses the importance of clarifying licensing requirements and eligibility to take the FRCP(C) examination prior to emigrating to Canada. However, he indicates that the MRCPsych is sufficient qualification to get a special licence. This used to be the case, but at present is true only in one province. I understand that all the other provinces require the FRCP(C). Another factor to note is that the Royal College of Physicians and Surgeons of Canada is insisting more and more on Canadian training. If the College does require additional training prior to taking the Fellowship examination, such training may not be easily available.

The emigration procedure is also very complicated. Emigration of physicians to Canada is very much restricted, and for all practical purposes, is possible only if the employer is prepared to sponsor the employee. Such sponsorship is usually available only for work in under-served areas. In some cases, there are restrictions as to how long one should stay in that particular scheme before one can move to another job.

I entirely support the general thrust of Dr Green's article. The professional climate in Canada is vastly different from that in Britain, and there are excellent opportunities in academic settings, public hospitals, and private practice, for suitably qualified psychiatrists.

P. M. DAS

*Royal Ottawa Hospital  
Ottawa, Ontario  
Canada*

### **Films of Psychiatric Interest**

Two films of psychiatric interest won bronze awards in the British Medical Association's film competition earlier this year: 'Illusions' an information film made for the DHSS about solvent abuse, and 'With Eyes Wide Open', the case history of a Scottish mentally handicapped artist.

'Illusions' runs for 40 minutes and is available on free loan as either film or video-cassette from CFL Vision, Chalfont Grove, Gerrards Cross, Bucks. 'With Eyes Wide Open' is a 56-minute film made by Dr Laurence Becker, 507 Park Boulevard, Austin, Texas, but it is hoped that a copy of the film, which has also won several other international awards, will be available from the BMA Film Library.

### **General psychiatrists—an endangered species?**

DEAR SIRs

A sizeable proportion of any psychiatrist's case load consists of neurotic illness occasioned by personal problems and worries. If, as Edward Hare<sup>1</sup> suggests, these patients would be better dealt with by separate non-medical therapists who are both interested in and specially trained in such work, this would leave the general psychiatrist a great deal more time to attend to other aspects of his work. Yes, but what would these be?

The major psychoses account for a relatively small proportion of any generalists case load and, in any event, as Hare points out, the causation being unknown treatment is 'largely palliative'. Such supportive psychotherapy as is needed for these unfortunate patients—and it is a great deal—is just as well given by the Community Psychiatric Nursing Service as by a doctor.

What of the other burdens of psychiatric practice? Such marital problems as come our way are probably better dealt with by those who have been specially trained in and are particularly interested in this field of work and have developed expertise in dealing with the complexities of marital problems.

So far as the phobic states are concerned, it would certainly appear that behavioural therapy in the hands of specially trained paramedical staff produces as good, if not better, results than those obtained by psychiatrists themselves.

Even in the forensic field, as Chiswick<sup>2</sup> has recently pointed out, the psychiatrist is no more competent than anyone else to pontificate on such matters as the quasi-medical defence of diminished responsibility, the social and moral implications of which are nothing to do with psychiatry. What is left for the poor old generalist?

Personally, I'm glad that I retired before redundancy reared its ugly head!

ARNOLD PEARCE

*Yateley  
Camberley, Surrey*

#### REFERENCES

- <sup>1</sup>HARE, E. (1985) In conversation with Edward Hare: Part II. *Bulletin of the Royal College of Psychiatrists*, 9, 46-48.  
<sup>2</sup>CHISWICK, D. (1985) Medicine and the law: Use and abuse of psychiatric testimony. *British Medical Journal*, 290, 975-977.

The BMA's annual film competition was established in 1957 and attracts around 100 entries from this country and abroad each year. The prize-winning psychiatric films are all shown at College meetings.

T. L. PILKINGTON, *Convenor, A-V Group*

### **Child and Adolescent Psychiatry Specialist Section, 1985-87**

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