Correspondence

Psychiatrists in training

Sir: Regarding the complaint of P. De Vries (*Psychiatric Bulletin*, **20**, 52–53) that psychiatrists in training are often tormented by the need to pass professional examinations and at the same time develop patient care skills, I cannot see a conflict between preparing for the MRCPsych, and improving all aspects of clinical practice. The knowledge base acquired has clear value in day to day patient care and encourages an informed and reasoned approach.

The pressure to pass higher examinations ensures we become familiar with this important body of knowledge. The MRCPsych examination includes an evaluation of the candidate's patient care skills. I have found these skills most noticeable by their absence in trainees who go on to fail. Passing the membership is the beginning of stressful competition for posts and guidance can seem inadequate at times.

I would reject as cynical and sensational the statement that many who pass the membership become self-seeking or burnt out. Doctors in all branches of medicine are subject to considerable stress and job satisfaction appears to be at an all time low. There are other more obvious causes for this than professional examinations such as low pay, changes to working practices, underfunding of community care, and balancing responsibilities to our families and patients.

The examination for MRCPsych is under constant review and is not in need of replacement with inferior tests of trainees' abilities.

B. C. TIMMINS, *Duchess of Kent Hospital, North Yorkshire DL9 4DF*

Sir: We have to agree with quite a few of Dr Timmins' comments. The knowledge required to pass the MCQ examination 'may' have value in patient care but does not 'commonly'. For instance "A patient being treated with a MAOI should not eat A: broad bean pods; B: banana skins . . ." No patient has ever asked us an MCQ!

Regarding patient care skills, we are not entirely clear what makes a 90 minute clinical examination 'superior' to 6 months' continuous evaluation with a supervising consultant? We are making no attempts to be "cynical and sensational" but sadly there is a stronger correlation between pass rate and exam oriented training than with patient care skill or experience.

P. DE VRIES, *Fulbourn Hospital, Cambridge CB1 5EF*; A. MICHAEL, *Department of Psychiatry, Addenbrooke's Hospital, Cambridge CB2 2QQ*

"Toys for the boys"

Sir: The Registrar of the College has written about the Fellowship (*Psychiatric Bulletin*, **20**, 185–187). One possibility left unconsidered is the abolition of the Fellowship or "Toys for the Boys" as it might well be called.

Is it really necessary to have this distinction? It is clear that the Fellowship is a self-perpetuating oligarchy which will tend to exclude those who have a low profile on the national or regional scene, but may still be doing good work in their locality.

Fortunately, the only privilege of the Fellowship is to pay an increased subscription to the College and to have the opportunity to stand for President. Neither of these will have much appeal to many members! Although it could be argued that excluding members of the College from election to high office is fundamentally undemocratic and ensures that senior officers of the College can never be truly representative of the membership.

I propose the abolition of the grades of member and Fellow and would welcome suggestions for an appropriate new all-encompassing title which would be won by examination.

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The use of high-dose antipsychotics in rapid tranquillisation

Sir: Hillam & Evans have reported that the majority of patients in an ICU were receiving antipsychotic drugs in doses exceeding the BNF recommended maximum doses and that polypharmacy was the rule rather than the exception (*Psychiatric Bulletin*, **20**, 82–84).

In their survey of rapid tranquillisation, Simpson & Anderson (*Psychiatric Bulletin*, **20**, 149–152) state that most psychiatrists use sensible drug regimes for rapid tranquillisation. However, the *median* maximum doses which their respondents would give were close to the BNF maxima, implying that half would consider exceeding these doses. At the same time they note that many psychiatrists believe that

emergency situations may warrant higher doses of antipsychotics than those recommended in the BNF.

These findings suggest that current thinking on and practice of the use of high-dose antipsychotics by many British psychiatrists is not based on the best available evidence. Controlled studies have consistently failed to show an improved clinical response to higher dose regimens or with higher plasma concentrations (Baldessarini *et al*, 1988). Further, there is little pharmacological justification for using high-doses as near maximal dopamine receptor occupancy occurs at modest doses (Farde *et al*, 1992).

The fact that the evidence seems to be ignored only makes more worrying the deficiencies in training and practice highlighted by Simpson & Anderson. The Royal College consensus statement recommends performing an ECG and other physical checks on patients on high doses. In emergencies where rapid tranquillisation is required, the risks associated with high doses seem to be greater (Baldessarini *et al*, 1988) and there are often very practical difficulties in carrying out the necessary physical monitoring (Cornwall *et al*, 1996). As alternative treatments (for example, the use of benzodiazepines and the provision of special nursing supervision) are available which do not require the same degree of physical monitoring, there seems to be little or no justification for the use of high-dose antipsychotic medication for rapid tranquillisation.

BALDESSARINI, R. J., COHEN, B. M. & TEICHER, M. H. (1988) Significance of neuroleptic dosage and plasma level in the pharmacological treatment of psychoses. *Archives of General Psychiatry*, **45**, 79–91.

CORNWALL, P. L., HASSANYEH, F. & HORN, C. (1996) High-dose antipsychotic medication: improving clinical practice in a psychiatric special (intensive) care unit. *Psychiatric Bulletin*, in press.

FARDE, L., NORDSTROM, A. L., WIESEL, F. A., *et al* (1992) Positron emission tomographic analysis of central D1 and D2 dopamine receptor occupancy in patients treated with classical neuroleptics and clozapine. Relation to extrapyramidal side effects. *Archives of General Psychiatry*, **49**, 538–544.

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What is an Afro-Caribbean?

Sir: In their article (*Psychiatric Bulletin*, **19**, 700–702) Drs Hutchinson and McKenzie argue that ". . . there is little justification for the continued use of the term Afro-Caribbean . . ." in medical research, on the basis, essentially, that there is no such precise entity as an "Afro-Caribbean person", and therefore that research which refers to Afro-Caribbeans as a group will be "scientifically flawed and likely to yield misleading results". Yet, in the November 18th issue of the *BMJ* (Vol. **311**, 1325–1328) McKenzie *et al* report their findings about the prognosis of psychotic illness in Afro-Caribbean people! So while repudiating the term Afro-Caribbean in the *Psychiatric Bulletin*, McKenzie uses it to report his research in the *BMJ*.

I suppose that, like most of us, Dr McKenzie is grapping with intangibles here: the nature of ethnicity, and the relevance of ethnicity as an epidemiological variable. I hope that he and his associates will continue to give good thought to this matter. In the meantime, I have a few questions for them.

Why, for example, do Hutchinson and McKenzie take issue only with the term Afro-Caribbean? Does this mean that they accept, as valid epidemiological variables, the other designations used by the OPCS and the Department of Health in naming ethnic groups? Do not their arguments against the term Afro-Caribbean apply just as much to all the other designations? And if we do not refer to a certain group of people as Afro-Caribbeans, what do McKenzie *et al* suggest that we should call them?

I. O. AZUONYE, *West London Healthcare NHS Trust, Uxbridge Road, Southall, Middlesex UB1 3EU*

Sir: Discussions about research into ethnic differences often find themselves in the cul-de-sac question of what exactly is the right name for an ethnic group rather than on more fruitful considerations of underlying research principles.

My joint article (*Psychiatric Bulletin*, **19**, 700–702) tried to make investigators think twice before they carry out research which looks at Afro-Caribbeans as a homogeneous cultural group. It highlighted the diversity of Caribbean peoples and concluded that more specific terminology should be used because the term Afro-Caribbean disguises this diversity. A research project which hypothesised that the reported increased incidence of schizophrenia in "Afro-Caribbeans" was due to their culture would need to define the "Afro-Caribbean" group in detail to be able to interpret results properly because the group is so culturally heterogeneous. The same is likely to be true of biological hypotheses because of the variety of origins of Caribbean peoples.

However, in research which looks at discrimination and social adversity it is possible to look at "Afro-Caribbeans" as a homogeneous group. Discrimination against people of Caribbean origin in the UK ignores cultural diversity and in this context the term "Afro-Caribbean" merely mirrors the social demarcations through which discrimination is meted out. The term has no cultural or