

psychiatrists understand and use the notion of "cannabis psychosis" – was not my own idea: that I made clear in title and text, and indeed was one of the reasons for preparing the work for publication. Psychiatrists, as I noted, must now be prepared to carry out research projects suggested by the minority groups whom for so long they have treated as the objects of "disinterested" academic research.

In the study in question I carried out the work in my own way, and the groups concerned were not collaborators in the method nor in implementation. That might perhaps be our next step; indeed even offering our professional research procedures to psychiatric service users and their communities to use as they see fit. That was not intended in this study, nor have I claimed it to be so.

I am *accountable* to the groups who advised me; they are not however *responsible* for the way I carried out and used their suggestions. Given the power of psychiatry I certainly think we should be wary of claims that we carry out research *on behalf of* others, but we can hardly hold others accountable for our actions.

That issues of quite serious responsibility are involved is perhaps indicated by reviewing the history of "cannabis psychosis" in Birmingham. In the 1970s it was not apparently diagnosed among either blacks or whites (Royer, 1977).

By the mid-1980s it was diagnosed 95 times more commonly in local Afro-Caribbean patients than in whites, and was an issue given extensive coverage (McGovern & Cope, 1987). The heavily publicised research project was then started. By 1988 the diagnosis had disappeared completely (Milner & Hayes, 1988a, b).

Whether this is something one "takes the credit" for (Dr Cook's phrase) depends on the future standing of cannabis psychosis: if it becomes a recognised category then clearly the paper will hardly be regarded with enthusiasm. Blame or credit, I remain accountable. (Alternatively one might argue that it was irrelevant, that it was merely part of a general lay and professional unease with the diagnosis.)

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Let the old man drink

DEAR SIRS

The physiological changes of ageing make the elderly more vulnerable to alcohol (Vestal *et al.*, 1977). Organic brain affliction, and cardiac and pulmonary diseases increase this sensitivity further. Alcohol in them, even in small doses, can cause acute confusion, disinhibited aggressive behaviour, sleep disturbance and emotional lability (Schuckit, 1982). Despite the Royal College of Physicians' advice on the safe drinking limit, such limits in the elderly are still unknown.

Failure of doctors to recognise the social decline and relying on abnormal physical signs for diagnosis creates difficulty in detecting the problem drinker (Murray, 1986). But surprisingly we find some psychiatrists, despite evidence of alcohol's contribution to the ill health in their elderly patients, are reluctant to wean them off. On the contrary, they "prescribe" "whisky" or "brandy" to some as a daily dose or as a night sedation. The rationale of this approach is (a) it is too late to treat; (b) he has lived so long, leave him alone; (c) it is a pity to take away his favourite drink. We agree with the elderly people's right to enjoy a drink, but believe that the sick elderly should be advised to stop drinking.

Although *Proverbs* (31:6,7) quotes, "Give strong drink unto him that is ready to perish, and wine unto those that be of heavy hearts. Let him drink, and forget his poverty, and remember his misery no more", this pessimistic and do-nothing view is at variance with our understanding in the field of geriatrics. The future welfare of sick aged people depends on more optimistic endeavours.

We look forward to readers' comments on this matter.

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Grading of nurses

DEAR SIRS

I have just discovered that the staff nurses, who work with me in our psychiatric day hospital, have been