on regimes meeting all three BNF advices but 15 were outside. Of this 15, eight were above BNF limits; two failed one indicator, six failed two, and seven failed three.

Thus, a careful reading of the BNF highlights more drug regimes of potential concern than just dosage. Sometimes, e.g. small doses of two drugs, the departure seemed technical, though not insignificant (n.b. compliance, interaction). In other cases, the departures seemed more substantial, perhaps especially from a potentially medico-legal point of view.

I wrote to the BNF about the exact legal status of its advice: the editor of the Joint Formulary Committee replied: "it is intended to provide general guidance ... if you and your colleagues wish to establish alternative protocols, you are, of course, free to do so ..." However, since the recent advice from the College's General Psychiatry Section Psychopharmacology Subcommittee that "very high doses ... should be the treatment of last resort", to exceed BNF dose without careful consideration and possibly a second opinion may leave oneself exposed.

It needs to be debated whether this also applies to BNF advice on route and polypharmacy.

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References

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Registrar's note: Council has recently approved a statement on high dose antipsychotic medication (available as CR 26). This guidance has been adopted by the BNF for its forthcoming edition.

Personality disorder; a declining diagnosis?

DEAR SIRS

In the early hours one morning, I saw an angry, drunk patient in Casualty. Diagnosis was difficult but I was greatly helped by finding in his old notes, that following attendance once at a day hospital in 1978, he had been given the diagnosis of "personality disorder". Following a full assessment and with this additional information, I eventually felt confident about discharging him to out-patient follow-up, whereas otherwise I would have unnecessarily admitted him.

With the advent of the Data Protection Act, patients are now able to see their notes. On several occasions, I have observed multidisciplinary colleagues tending to leave out personality disorder as a diagnosis "in case he/she sees his/her notes".

One wonders also whether GPs may be tempted to omit this diagnosis from referral letters and psychiatrists to omit it from discharge summaries. This would lead to partial or incorrect diagnosis and skew audit or service planning.

Do other doctors have evidence that this is occurring?

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Self-treatment for early waking

DEAR SIRS

You are bound to think it somewhat impertinent for a layman to write to you in this vein, but I hope you will find it justified.

For several years I have suffered from depression, suicidal at times; now having stumbled across a very effective self-treatment, I feel I want to pass the idea on in some quarter where it may be used. On the other hand, I must recognise that the underlying principle of it may be "old hat" and already well exploited. I am 78.

Like most depressives, I always woke early in the morning, even if I was taking something to help sleep. It seems to me that it is during the wakefulness of the small hours that the little black dog comes along and starts bad thoughts which set the tone for the ensuing day.

My treatment has been to accept the early waking, sit up in bed (extra pillows) and have a hot drink from a thermos. The drink, I suppose, could be anything, but for me Ribena works best. This is the moment to wash down a partial dose of sleeping pill. In my case it's Lorazepam (Ativan) which, in spite of the things said on the media, I confirm to be a truly mild anxiolytic with no side effects. The tablets can be cut with scissors, and my 3 a.m. fragment gets less and less, say 1/3 mg, now mainly a placebo. A little biscuit may further help.

The resultant change in my mood was so prompt when I started this on New Year's Day that it could not be dismissed and the effect has now endured for seven months. I used to dread every night; now I look forward to it, feeling that I get two deep sleeps for the price of one. The interval after the snack can be spent reading, writing or just relaxing, until sleepiness returns.

One sees that all this could be disturbing to a spouse who did not sleep deeply. Depending on space, a good solution is beds apart with a screen between. Further than that, the drastic arrangement

of separate rooms seems to be justified by the benefit received.

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Impressions of South African psychiatry

DEAR SIRS

Professor C. L. E. Katona discussed undergraduate training in psychiatry and mentioned that the greatest exposure (eight to ten weeks) occurred at the University of Pretoria (*Psychiatric Bulletin*, February 1993, **17**, 106–108). We would like to correct this impression, as the Department of Psychiatry under Professor W. H. Wessels, University of Natal, Durban was the first department to provide ten week exposure to clinical psychiatry spread over the fourth to sixth years of undergraduate medical training. The extended clinical training in psychiatry was introduced in 1983.

It is unfortunate that Professor Katona did not avail himself of the opportunity of visiting our medical school which has been responsible for the training of the vast majority, by far, of black doctors and black psychiatrists in South Africa.

We would like to add that we are particularly proud of the standard of psychiatry taught at our medical school.

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DEAR SIRS

I am grateful to Drs Lasich and Nair for clarifying the question of undergraduate psychiatric training in the University of Natal.

I would very much have valued the opportunity of visiting their Department. Sadly, a trip as short as mine could not hope to be comprehensive—as I hope I made clear in my article.

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A clinical dilemma and its solution

DEAR SIRS

I would like to relate a clinical dilemma and its solution, which confronted me when on duty at my hospital.

It concerns a 37-year-old male patient with paranoid schizophrenia who had defaulted on depot medication. Having relapsed with paranoid delusions, he presented to the hospital, lying half naked on the front lawn. There he remained passively mute, refusing to respond to inquiry or instruction and, as it was bitterly cold, I was left with little option but to seek his compulsory admission. After satisfying the requirements of the Mental Health Act, which took a few hours, we were faced with a major logistical problem; he weighed 24 stone and it was a long way to the ward.

Attempts with all available muscle power failed miserably, resulting only in strained backs and bruised egos. One suspected that the patient was enjoying the experience of seeing those who earlier appeared authoritatively in control reduced to embarrassed exhaustion. When all appeared futile, a nurse came to the rescue after commandeering a wheelbarrow from the gardener and only with this were we able to affect his admission.

The patient, on making a full recovery, recalled the event with amusement and was grateful for the initiative. This highlights that no good psychiatric unit should be without an accessible, well-oiled, sturdy wheelbarrow.

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