and explanatory theories of generalisable validity of mental phenomena (Frommer & Frommer, 1990).

A discussion between philosophy and psychiatry may stimulate not only the topic of nosology and categorisation, but also basic epistemological efforts, integrative work at the interface of different language games within psychiatry (Langenbach, 1993), and the link between psychopathological phenomena and everyday life. After all, psychiatric patients are members of the shared social world. Accordingly, philosophy can sharpen concepts of the mental, e.g. by introducing qualitative methods of understanding and researching.

One of the most useful contributions of philosophy to psychiatry, especially in times of prevailing and virtually exclusive methodological interest in operationalisation, is the facilitation of fluid thinking. According to Novalis, a philosopher-poet two centuries ago, philosophy "frees everything and relativises the universe. It neutralises the fixed points, as does the system of Copernicus, and makes the resting a floating".

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SCHWARTZ, M.A. & WIGGINS, O.P. (1986) Logical empiricism and psychiatric classification. *Comprehensive Psychiatry*, **27**, 101–114.

MICHAEL LANGENBACH and JÖRG FROMMER, *Department of Psychosomatic Medicine and Psychotherapy, Hienrich Heine University, Düsseldorf, Germany*

Sir: I agree with much of what Drs Langenbach and Frommer say, and am rather surprised that they found my article hostile to their approach to philosophy.

The Philosophy Special Interest Group, while encouraging high standards of philosophical thinking, does not require adherence to any philosophical school. Indeed, many of our members, especially those with psychotherapeutic interests, share Drs Langenbach and Frommer's distaste for logical empiricism. I feel sure the Group would give their views a warm welcome.

I would like to correct one misconception they have: they have implied I believe that Carl Hempel's concepts of classification underpin what psychiatrists actually do. As they so rightly point out, this is not so. However, his work did allow psychiatrists to come to agreements with each other about what would be called schizophrenia, for example. Without such agreement, meaningful debate is of course impossible. Even Martin Buber considered meaning had to be shared before one could relate to the Other (Buber, 1984). So, Hempel's work is a good example of the *utility* of philosophy for psychiatry, which was why I chose it. Psychiatrists are practitioners, and rightly require demonstrations of utility as well as truth.

It is, of course, important to debate which philosophical methods are best for addressing which psychiatric problems. I look forward to Drs Frommer and Langenbach developing their arguments in more detail.

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GPs' attitudes towards sectorisation

Sir: I read with interest Eluned Dorkins article 'Towards sectorised psychiatric care – what do GPs think?' (*Psychiatric Bulletin*, 1993, **17**, 594–596).

Our Community Health Care NHS Trust has a population of 198,000 of which 60% are registered with GP fund-holders. Having three general psychiatrists, we thought it opportune to 'sectorise' our service for general psychiatry and wrote to all general practitioners with the proposal. The response as a whole was unequivocal and sharp, objecting to not having been consulted, lack of choice of consultant psychiatrist and the difficulties GPs had been experiencing post sectorisation in neighbouring health districts.

Although we felt that sectorisation would have led to a better service, we succumbed to the pressure.

This case illustrates the strength of the market-orientated customer given service and the compromises one has to make within it.

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The Calman Report on specialist training

Sir: I would like to respond to the articles by the President and Dr Kisely on the Chief Medical Officer's (Calman) Report on specialist training (*Psychiatric Bulletin*, 1993, **17**, 577–579 and 610–612) on behalf of the CTC.

The CTC welcomes the general recommendations and principles of the Calman Report. We support the President's view that minor changes, building on our current achievements, are needed to meet these recommendations in psychiatry. Policies regarding the structure, content