which we do with the Samaritans. I have discussed this with Dr J. L. T. Birley, who is the medical consultant to the Samaritans, and he agrees with me that it would be useful to organize a meeting which would take place at about the same time as a quarterly meeting of the College.

It would be an informal meeting and as such we cannot expect it to be included in the already busy programme of section, group and other business meetings which are held between the formal sessions of a quarterly meeting. What is proposed is a meeting which would take place on the afternoon or evening before a quarterly meeting or on the evening or morning after a quarterly meeting.

Since there will be a session on parasuicide at the Autumn Quarterly Meeting to be held in London on 14 and 15 November 1985 this might be the most appropriate opportunity, but we could meet at the time of one of the other meetings. If other branch psychiatrists are interested, I would be grateful if they would let me know.

KEITH J. B. RIX

St James's University Hospital
Leeds

The 'Ivory Tower' vs. 'the poor nation of others'

DEAR SIRS

I read with interest Professor Goldberg's comments on my article (*Bulletin*, April 1985, **9**, 83) and his statistical 'evidence' that the University Hospital of South Manchester relatively gives better patient care, with less resources, to a larger population than Prestwich Hospital, while at the same time it conducts far more teaching and research. The inevitable conclusion from this paradox, Professor Goldberg would no doubt have us believe, must lie in the superior intrinsic quality of his academic staff; and this is, indeed, the issue I wish to contest, i.e. the widely held but erroneous view that academic excellence implies, as if by definition, good patient care.

While agreeing with Professor Goldberg that the two terms are not contradictory, I maintain they are distinct and not interchangeable, e.g. asking for money for patient care when you want money for research. The advantage really lies where resources go and patient care should, certainly more often, be given priority.

VICTOR S. NEHAMA

Prestwich Hospital
Manchester

DEAR SIRS

Without wishing to be too pedantic, or to prolong the argument, I feel that I must comment on Professor Goldberg's assertion (*Bulletin*, April 1985, **9**, 83) that the Ivory Tower in Manchester undertakes equal or greater patient care compared with the 'poor nation of others'.

As any researcher will know, we must compare like with like and a more accurate comparison would be, Ivory Tower DGH versus North West Peripheral DGH. Professor Goldberg is well aware of the results of that analysis.

In addition, Professor Goldberg's assertion that 45 per cent of his referrals come from outside the catchment area is well covered by the funding of several Regional Units at his hospital. Our own District's figure of 33 per cent from outside the catchment area is covered by no such Regional funding.

MICHAEL A. LAUNER

Burnley General Hospital
Burnley, Lancs.

[We invited Professor Goldberg to reply—Eds.]

DEAR SIRS

My letter was not intended as a criticism of my colleagues at Prestwich Hospital, but merely as a defence against Dr Nehama's original suggestion (now withdrawn: thank you) that there is some necessary antithesis between academic psychiatry and patient care. I quoted a few figures to make the point that we do not lean on our spades where clinical work is concerned, and I am very pleased that Dr Tarsh has, on behalf of his colleagues, publically disassociated himself from Dr Nehama's original article by acknowledging that we do 'do a very large amount of excellent clinical work' (*Bulletin*, June 1985, **9**, 122).

I may have annoyed my consultant colleagues at Prestwich by drawing attention to the fact that they are not under-resourced. Dr Tarsh now writes that resources being spent on us should be spent in areas from which our patients originate: this is of course already being done, and in the long run it will hurt Salford perhaps even more than South Manchester.

I have considerable sympathy with Dr Launer's letter. Of course I am 'well aware of the results of that analysis', since I was responsible for actually carrying it out.[1] The standard DGH model service is seriously under-resourced in terms of total medical staff, nursing staff and 'other therapists', and it is therefore cheaper than ours, and very much cheaper than services based upon the mental hospital.

Your correspondents are all wide of the mark concerning patients attracted into the teaching area. Dr Launer is wrong in supposing that they are 'covered by funding of Regional Units'; Dr Tarsh is wrong in supposing that improving services peripherally will solve the problem (and also seems unaware of the cross-border flow into Salford!); and finally, Elaine Murphy is quite wrong with her silly and ill-informed sneer that our patients from outside are 'middle class people with minor ailments and a good prognosis' (*Bulletin*, June 1985, **9**, 121-22). I have worked in London teaching hospitals for much longer than she has, and can assure her that what may have been true of them once is certainly not true of us now. The point is worth stating, not only on our behalf but on behalf of Guy's, which is faced with dwindling resources every bit as much as we are: *tough cases are referred to teaching hospitals*.

A significant proportion of my clinical work load are people referred by their GPs for a further psychiatric opinion, as well as many cases referred directly by my consultant colleagues. There is nothing 'shameful' about such work: if Professor Murphy does not do it, there is something peculiar about her academic unit. However, I am sorry I made her blood boil, since that was presumably responsible for the meaningless