clinical skills under such artificial conditions may not be valid or reliable.

The reliability of essays as part of the exam is questioned by Professor Trethowan. Drs Aveline and Thompson feel they have merit because they can test ability to communicate, ability to show critical judgement and test a wider area of knowledge. One surely must agree with Professor Trethowan that there are better ways to test the ability to communicate and this is not what the exam is for. He suggests a modification to a number of 'short-answer' questions. I should like to suggest a different type of replacement for the essay in Part II of the MRCPsych. The research option has been unpopular, and in my personal experience requires much more work than the small part of the exam it replaces. However, I feel that a valuable aspect of it is the encouragement to study a wider area of the literature on a specific topic and the encouragement to *think* about how a problem in psychiatry might be approached. I propose a modification of this option to a compulsory dissertation of, say, 5,000–7,000 words. This need not include any actual research work or results (though could if a candidate so wished) but would be an extensive review of an area of psychiatric literature of interest to that candidate, with reference to some unresolved problems in that area and perhaps suggestions as to how they might be tackled. In the instance of a candidate interested in psychotherapy or behaviour therapy, he or she might include a discussion of a particular form of therapy and illustrate this with a case or cases treated personally. The titles for such dissertations could, if it was felt necessary, be approved by either an examinations committee or the candidate's local Professor. I believe this type of innovation, instead of essay questions, would be the best way to test the ability to appreciate a wider area of knowledge and the ability to show critical judgement. In addition, it would be carried out in the absence of 'exam nerves', might stimulate people to think more clearly about problems and could stimulate research. For overseas candidates who may find the task of writing essays a greater task than others, it would allow more time for them to express themselves to the level of which they are really capable.

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Videotapes on psychiatric subjects

DEAR SIRS

Professors Seager and Goldberg (*Bulletin*, November 1982, **6**, 203–4) are to be commended for pioneering the use of videotape in training young psychiatrists to give ECT and for making their tapes available.

Inevitably these first productions are not wholly satisfactory and should be viewed critically. The Sheffield videotape is the better.

I am particularly concerned that the Manchester tape is offered for self-teaching for it contains errors of fact and technique. The tapes will be a useful aid to learning but not a substitute for full theoretical and practical training by those experienced in ECT. They ought to be discussed with learners when they are seen.

No doctor should administer the treatment unsupervised until the responsible consultant is satisfied with his knowledge and skill.

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DEAR SIRS

The recent flurry of publication, discussion and publicity has ensured that most doctors are alerted to the problem of alcoholism. Unfortunately some doctors, particularly those in training, are still unsure about what to do when confronted with a problem drinker. The result of this uncertainty is, not infrequently, frustration, irritation and despair for both the doctor and the patient.

The Department of Mental Health at the Queen's University, Belfast, has recently produced a new videotape, which is especially appropriate for use with medical students and junior medical staff, in either hospital or general practice.

The tape is called 'The Alcohol Dependence Syndrome—A Psychological Approach' (colour, 47 mins). It presents guidelines on the assessment of the problem and a model for understanding approaches (cognitive, psychodynamic and existential). The tape follows the progress of one young man through his time in the regional treatment centre, and deals realistically, but enthusiastically, with the often daunting process of rehabilitation.

The programme may be copied on to your own blank U-matic, VHS or Betamax cassette at a cost of £15. It is available from Mr Brian Patton, Audio-Visual Unit, Department of Mental Health, The Queen's University, Belfast, 97 Lisburn Road, Belfast.

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Psychology of nuclear disarmament

DEAR SIRS

I found Neill Simpson's letter (*Bulletin*, November 1982, **6**, 202–3) puzzling and on closer inspection disturbing in its form. The first paragraph sets an analogy, novel to me, between the deterrent effect of nuclear weapons and addiction to drugs, only to knock it down immediately. The second paragraph leads us from this analogy to a consideration of the fact that information is sometimes withheld from

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the public to avoid arousing 'too much alarm'.

Thus far the argument can be followed quite comfortably, but the next paragraph is distinctly alarming and the last positively frightening in its implication that we must all expect to be involved by officialdom in some plot to 'treat' those whose views are politically heterodox.

Let us pause before we panic. I think we may assume Neill Simpson has no solid evidence of 'official encouragement to treat non-morbid fear of nuclear war' or he would surely have provided it for us. In any event, though such a thing is not beyond the realms of possibility (what is?), it is difficult to envisage the form it would take. Am I to expect dozens of CND demonstrators deposited at my hospital by the local constabulary under Section 136? Will I be receiving a discrete phone call from our regional medical officer? Are our masters at Elephant and Castle about to circulate us with some highly confidential instructions? Not very likely, is it?

Assuming, as I think we must, that Neill Simpson's speculations are entirely groundless, why has he offered them for our consideration? I would like to offer the following tentative 'analysis'.

I think that an attempt is being made to link two separate issues. We are all of us, whatever our views about nuclear weapons, united in holding in abhorrence the idea of ourselves as psychiatrists being used to further the dubious ends of some dictatorial regime. I suspect that Simpson is attempting to harness this abhorrence and turn it to his own use. He seems to be trying to manipulate our emotions.

Such a linkage of two separate but equally emotive issues hardly sparkles as an example of honest argument. As a ploy it has long been favoured by the dreary exponents of propaganda.

Now I may be completely failing to understand the situation and gravely misjudging Simpson's motives, but if this is the case, it should be easy for him to prove—all that is required is a little evidence.

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Issues involved in rehabilitation

DEAR SIRS

In recent years there has been a marked increase in the numbers of consultant psychiatrists appointed with responsibility for rehabilitation. At the present time, no one knows exactly how many, who, or where, nor are the opportunities for training in rehabilitation known.

There is some demand for a forum where psychiatrists involved in rehabilitation can discuss matters of mutual concern, and as a first step towards this it would be helpful to identify the people concerned.

Therefore, psychiatrists with any sort of commitment to rehabilitation are invited to write to me describing briefly what their responsibilities are, how much time they give to rehabilitation and what training they provide for junior doctors and for other staff.

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Psychiatric experts and expertise

DEAR SIRS

I was very pleased to read the letter by Arthur Kaufman (*Bulletin*, September 1982, **6**, 662–63).

It would appear that Mr Kaufman (on behalf of properly trained clinical psychologists with experience in the diagnosis and treatment of mental disorder) is only too pleased to be asked to go into Court and comment freely on the diagnosis of early dementia and advise lawyers to challenge a medical person's competence to offer an expert opinion in some instances relating to brain function.

I am pleased to read this because I am glad that someone is willing to take it upon themselves to act as a 'punchball' in a public arena of a Court of Law, where both the game and the rules of the game are foreign to his training and experience.

It should be remembered that for all the many Ph.D.'s and learned articles that an expert may have published, when it comes to the art of debate, cross-examination and the ability to think logically on one's feet, all of us are pathetic amateurs compared with a skilful and trained barrister.

Furthermore, to go into Court as an expert witness on topics as vague as psychology, sociology or psychiatry, with no true scientific basis, little provable knowledge and to give opinions based on statistical analysis and other soft facts, in my experience is going to provide a field day for an experienced legal expert.

I have been involved in many Court cases as an expert witness. It is part of my duty to my patients. Nevertheless, I still 'quake' in anticipation of the worst and I have the greatest respect for the legal profession's ability to make mincemeat out of my so-called 'expert' status.

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