Sir: The council must ensure that the College's work is pursued as its Charter requires.

It is difficult to see how this can be achieved if Members could 'pick and choose' which College activities their subscriptions should fund.

Perhaps the Welsh Division would see no need for the English Divisions, or the Child Psychiatrists dismiss the Section of Old Age!

It can further be argued that we are in a system that is fragmenting at the present time and that we can best maintain and even improve standards of psychiatric care through cohesion and collaboration.

F. CALDICOTT
*The President, The Royal College of Psychiatrists*

## Alice or Mrs Cooper?

Sir: Hospital staff often approach elderly patients with an over-paternalistic and over-familiar attitude. They frequently assume – without consulting the patient – that he or she prefers to be addressed by his or her first name, rather than the family name. Many nurses and doctors believe that this promotes a warmer and more trusting interaction. However, the patient is not allowed to make the assumption that doctors prefer to be addressed by their first name. In fact, most elderly patients would never call the doctor by their christian name. This inequality reinforces the idea that the doctor–elderly patient relationship is the expression of the interaction between the powerful and the powerless. Nurses have more intimate contact with patients, an essential component of therapy, particularly in a psychiatric setting. However, it would be wrong for the nurse to assume that the patient favours a familiar treatment over a more formal one.

Previously, we found that those who use our psychogeriatric service prefer to be called patients rather than clients (Cybulska, 1994). We now report that 86% of 50 patients consulted in this unit, as well as in a local geriatric ward, prefer to be addressed by their christian or middle names while in hospital. Nurses in our services now ask the patient on admission how they would like to be called which is recorded in the notes. Familiarity is warm, but only when exercised with consent and equality, and not as a power statement.

CYBULSKA, E. (1994) Patients, not clients – a community survey among elderly patients. *Psychiatric Bulletin*, **18**, 509.

RAFAEL EUBA
*Stone House Hospital, Cotton Lane, Dartford, Kent DA2 6AU*

## Trainees, coffee rooms and missing notes

Sir: I write to report two indirect consequences for trainees of the closure of larger psychiatric hospitals.

First, the emergence of smaller, geographically dispersed sites and subsequent shifts in medical resources and clinical commitments have signalled the death of 'coffee room psychiatry'. New units often lack a focal point for doctors, or geographical isolation prohibits attendance, meaning consultants and trainees have difficulty meeting for a relaxed lunch (if they still take lunch!), to discuss issues of the day away from the glare of formal case conferences and among sympathetic peers. This informal 'supervision' was often an integral lifeline to maintaining morale and good communication.

Second, dispersal of patient services has a similar effect on medical records and notes' availability. Increasingly, community mental health teams hold notes locally, not centrally. This has implications for trainees who are increasingly being asked to formalise their research base (Owens *et al*, 1995).

For example, in Nottingham notes are now kept on two hospital sites but also at six community team bases. I attempted to review 1600 case notes as part of an MMedSci project. Apart from the expected attrition of some lost notes or those in use, 25% were unavailable since they were missing or at other sites, making review increasingly lengthy and difficult. Since retrospective case-control studies from case notes are often the 'bread and butter' of small research projects by trainees with limited research time, unavailable notes could provide significant feasibility and sample time problems and trainees need to be aware of this.

OWENS, D., HOUSE, A. & WORRALL, A. (1995) Research by trainees. A strategy to improve standards of education and supervision. *Psychiatric Bulletin*, **19**, 337–340.

JOHN MILTON
*Nottingham Healthcare NHS Trust, Porchester Road, Nottingham NG3 6AA*

## The last of the Victorian mental hospitals

Sir: In the article by Cantwell & Brewin on the Nottingham undergraduate curriculum (*Psychiatric Bulletin*, August 1995, **19**, 482–484) there is repeated, as an aside, the claim that Nottingham is the first major metropolitan area to close down its last Victorian mental hospital. In fact Liverpool closed its mental hospital, Rainhill, in 1991.

For a time some of the city's acute services were operated from a Victorian general hospital, Sefton