curriculum. When our medical school was established in 1981, the teaching of the behavioural sciences course was run by one academic and one clinical psychologist and students' responses appeared unsatisfactory. Over the past two years, psychiatrists have taken over the course, which consists of a variety of lectures on medical psychology and sociology. The general approach is to teach basic psychological and sociological principles, illustrated with clinical examples. When one of us teaches Erikson's life stages during a lecture on 'young adulthood', for example, case histories are freely discussed of patients with depression, anorexia nervosa, etc. to illustrate how the failure to resolve conflicts earlier on in life may result in adult psychopathology. Students appreciate such 'story telling' as they seem to identify with clinicians more readily than with social scientists.

The course also includes a six-hour interviewing practical during which students in small groups interview patients and discuss communication skills. They are excited about visiting a clinical department, and are often as embarrassed as amused by teachers' feedbacks as they watch their awkward behaviours on the video monitor. That 'crazy' psychiatric patients can talk sensibly invariably makes a powerful impression on them. The whole exercise involves 120 teaching hours and is highly rated by students, one of whom wrote:

> "I felt that the practical is a golden chance for us to interact with patients in the preclinical years. Minor things that we usually neglect, such as greeting the patient politely, arranging the chairs, and using open ended questions, are in fact very important in doctor-patient communication or even everyday social interactions. It is exciting to see the faces of my classmates and myself on the monitor. There are so many awkward facial expressions and gestures to correct! After this practical, I have a much deeper understanding of the saying–to cure sometimes, to relieve often, and comfort always. I also learn that being a doctor does not merely mean book knowledge since medicine is a humanely conducted science."

We believe that a behavioural sciences course run by competent psychiatrists who continue to be keen to teach is an under-recognised source of enhancing students' attitudes towards psychiatric medicine.

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Validity of oral consent

Sir: I refer to the interesting case posed by Dr Alfred C. White (*Psychiatric Bulletin*, 1994, **18**, 507). I think the patient gave express consent in the form of oral consent which is legally as effective as written consent although obviously subjected to uncertainties. He willingly accepted ECT and thus gave implied consent. The consultant psychiatrist was satisfied that the patient understood the purpose, nature and consequences of the treatment offered. He appeared to have given sufficient information about ECT and the risks involved to satisfy the 'Bolam Test' (Bolam v Frien HMC 1957). Under the circumstances described I think oral consent was acceptable. I would suggest detailed records to be kept and a phone call made to the hospital's solicitors to confirm that the oral consent was valid.

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The Christopher Clunis enquiry

Sir: Jeremy Coid (*Psychiatric Bulletin*, 1994, **18**, 449–452) raised concerns about the ability of community services to protect the public from dangers associated with mental illness. However, I fear Coid has misinterpreted the main issue. He surmises, "The main importance of the Christopher Clunis enquiry is that it now poses very unpleasant questions about the ideology of health care delivery and the *routine clinical management of severely mentally ill persons* in the UK." (my emphasis). If I were a severely mentally ill person I would take great offence at his reasoning. The majority of severely ill patients are not dangerous. Dangerousness is not a feature associated solely with severity of illness. Some of the most dangerous patients I have dealt with are mild to moderately ill and of course the courts see many others who are not ill at all. The focus of concern should be how to manage those who (a) are chronically and intractably severely mentally ill and (b) have long-term problems with serious violence (as reflected in past serious acts of Clunis).

The main problems I have encountered in the community management of this group are:

(a) it does not take too long for clinicians to amass a worrying number of patients who may not only attack others but clinicians themselves. This erodes job morale

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