enables me as a psychiatrist to withdraw from treatment knowing the competency of support systems that will not alert services to future problems. Kellett's view that psychiatric services have moved away from the care of psychotic patients to allow more work with neurotic disorders in the community is not my experience of inner city psychiatry where our time is increasingly dominated by the care of serious mental illness.

Many of the problems in the for or against debate could be solved if the organisation of general practice were to change. If GPs become locality-based there could be co-terminous relationships between GP and specialist based on geographical catchment areas. GPs work the way they do for financial not clinical reasons. Choice of GP does not really exist for disabled, vulnerable patients who are practically bound to the local general practice.

Finally, Kellett suggests that mediocrity results from catchment areas stifling competition between consultants. Consultants are well paid professionals who have a contracted responsibility to develop and deliver a quality service with or without competition. Mediocrity is the result of mediocre doctors who believe they can make the minimum of effort once in a permanent position knowing there is lack of sanction against those who do a poor job. Ultimately, if all doctors were good at what they did there wouldn't be a problem. I doubt we can blame the catchment areas for that one.

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Bias in the assessment of psychiatric emergencies

Sir: We read with interest the article by Hall & Deahl on the inadequacies of history taking by trainee psychiatrists in casualty (*Psychiatric Bulletin*, September 1995, **19**, 538–540). While we agree that efforts are merited to increase alcohol and substance abuse histories in all groups, we disagree that this discrepancy is likely to represent ageist or sexist attitudes. The OPCS survey (Goddard, 1991) of drinking habits in the late 1980s (quoted in part in Hall & Deahl's article) found that 23% of men and 8% of women exceeded sensible drinking levels (21 units for men and 14 units for women). Excess drinking showed a decline with increasing age in both sexes. Based on these figures, if a full alcohol history had been taken in all cases at least a further 5.3% of men and 3.4% of women would have been identified as exceeding sensible drinking levels. The recording of disorders more likely to occur in a sub-population has a long history in medicine and we do not feel it should necessarily be dismissed as ageist or sexist.

Reference

GODDARD, E. (1991) *Drinking in England and Wales in the late 1980s*. London: HMSO/OPCS.

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Sir: We agree with Vanstraelen & Duffet that substance use occurs at different levels in different population subgroups. We also agree that it is clinically important to recognise such differences. However, in emergency clinic psychiatry we think that to let information about populations lead us into assumptions about individuals is clinically dangerous. One cannot exclude a diagnosis just because it is unlikely.

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Masters courses in psychiatry

Sir: We thought that the article by Shoebridge & McCartney (*Psychiatric Bulletin*, September 1995, **19**, 555–558) raised interesting questions. Having experienced the Cardiff MSc course, we would make the following points:

(1) The development of the MSc course acted as a catalyst to enhance greatly the quality of training for the MRCPsych in Cardiff. Few of us would see any advantage in a return to the 'old' MRCPsych course.
(2) In a rotation which is spread across South Wales, the MSc course has provided a focus and a route of access to the expertise of the academic department in Cardiff for supervision and advice.
(3) The research component means that trainees are encouraged to undertake research and learn research methodology earlier than they might.
(4) At its best, it provides a higher degree in psychiatry and a publication around the

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time trainees are looking for a senior registrar post. This may well give S. Wales trainees a 'competitive edge' in the race for jobs.

(5) The main problem appears to be the extra work involved, and especially the need to write a dissertation around the time one is preparing for the Part 2 MRCPsych. This can be particularly difficult for those who require several attempts at the examination.

Overall, we feel that the benefits of the MSc greatly outweigh the problems. Not everyone completes the MSc, and in this sense it is not 'compulsory'. It provides a good opportunity to get involved in supervised research and to obtain a postgraduate degree.

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Psychiatric training in police surgeon work

Sir: I would like to describe an experience of police surgeon casework and suggest that psychiatrists with an interest in Diversion from Custody might do some training with police surgeons.

I surveyed the cases seen over one year as a psychiatric registrar working on a one in six night time police surgeon rota in Ashington, Northumberland. This was supervised by a senior police surgeon and two consultant psychiatrists. Twenty-nine males and four females charged with offences ranging from drunken driving to murder were seen. Eighteen of these individuals had physical injuries and twenty-two were intoxicated with alcohol, drugs or other substance combinations. Two detained persons presented with DSM-III-R manic episodes and another two with adjustment disorders. The work generated by intoxication was substantial and our assessments appeared to make a marked difference on the rate of inappropriate Section 136 cases being taken to the local psychiatric hospital. A major benefit was acquiring an insight into the requirements of diversion from custody from the perspective of the police and forging working relationships with police officers. The police welcomed a psychiatrist as a police surgeon.

There are insufficient police surgeon recruits and the best way to train in the diversion from custody of mental disordered offenders is still being evaluated. There may be a case for trainee psychiatrists interested in becoming diversion from custody consultants joining the ranks of police surgeons. This should be at registrar or senior registrar level, with supervision from a consultant psychiatrist as well as incorporating police surgeon training.

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Stravinsky, Hogarth and Bedlam

Sir: I read the article on Stravinsky and the Rake's Progress by Paul Crichton (*Psychiatric Bulletin*, August 1995, **19**, 196–498) with interest, and incredulity. The Hollywood-style psychobiography of the composer in his late fifties shows some of the pitfalls and the pointlessness of such activity. Crichton's account of the years leading up to the opera's composition is misleading. He states that "... by 1947 Stravinsky's career was totally becalmed ... he had written a couple of untempestuous orchestral pieces ... He was depressed by the lack of originality ...". In fact, between his arrival in California in May 1940 and his encounter with the Hogarth print in May 1947 Stravinsky completed the Symphony in C (1940) and composed the following works: *Tango* (1940), *Dances Concertantes* (1942), *Circus Polka* (1942), *Four Norwegian Moods* (1942), *Ode* (1943), *Babel* (1944), *Scherzo à la Russe* (1944), *Scènes de Ballet* (1944), *Sonata* (1944), *Elegy* (1944), *Symphony in Three Movements* (1945), *Ebony Concerto* (1945) *Concerto in D* (1946), *Orpheus* (1947) and most of the *Mass* (1948) (White, 1979). These works all received their premières during this period and the list contains some of the most important and enjoyable music of Stravinsky's later years.

There is no evidence from contemporary memoirs that Stravinsky was 'depressed' and Robert Craft's assassination of the composer's character is presented out of context. One might wonder whether Craft's analysis was objective since in the same chapter he admits that "... our nervous systems and temperaments were virtually the same"; and later, "Stravinsky's personality was overwhelming and dominating ... and I had to seek refuge from it to preserve my identity" (Craft, 1992). As if by way of confirmation of Stravinsky's instability Crichton points out that he knew de Falla, Satie and Nijinsky – all of whom were rated as highly disturbed by Felix Post (1994). What relevance has this to Stravinsky's mental state in the 1940s?

Perhaps the final moral of the *Rake's Progress* (Auden & Kalman, 1951) itself should serve as a warning:

"For idle hands,
And hearts and minds,
The Devil finds,
A work to do,
A work, dear Sir, fair Madam,
For you and you".