Support and stay

DEAR SIRS

Dr Macdonald is quite right that there are "marked differences in the balance between health and social services provision for the elderly demented across the country" (*Psychiatric Bulletin*, April 1991, **15**, 224). The environment in his district sounds very different to that in our own.

The question remains about the difference between a psychogeriatric service and a social service. It is our opinion that caring for most dementia sufferers requires special skills. Given that much care will be provided by staff who do not have the benefit of a lengthy professional training, it seems to make sense to employ these people as part of a NHS psychogeriatric service. Within this service it is possible to arrange some basic training from doctors, nurses, OTs, physios, psychologists and even social workers. Furthermore, it enables the nursing assistants to have quick and easy access to the pool of expertise about dementia from these professionals.

We also do aim to offer our services to *all* clients with dementia.

None of this is to say that we do not work closely with social services, nor that we may not change in the future.

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Confidentiality and psychiatric practice

DEAR SIRS

J. V. McHale raises important forensic issues in her note (*Psychiatric Bulletin*, March 1991, **15**, 60) Recent legal decisions in the North Americas could well soon find their way to these shores. In those parts, it has been decided, in Tarasoff and other cases that mental health professionals can be held liable for failing to warn third parties of possible dangers to themselves (Mackay, 1990).

In a comparable field of activity, probation and parole officers in the USA have, in some instances, been held to be similarly so liable (though there have been conflicting judgments) (Sluder & Del Carmen, 1990). It is to be hoped that those in the indemnity business are busy exploring the implications of Egdell and the North American cases. Forewarned may well prove to be forearmed.

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Carpets for patients and staff

DEAR SIRS

Dr Jolley (*Psychiatric Bulletin*, March 1991, **15**, 168) obviously does not know what he is missing and it is not the smell!

Contrary to his philosophy, I determined that the new unit for my services which has both assessment wards and continuing care wards should be carpeted throughout.

Yes, I mean throughout patient and staff areas excluding only bathrooms and lavatories. Our patients have complete freedom of movement and are not required to wear catheters. They are regularly taken to the lavatory by nursing staff and it is the high quality of nursing care which underpins the success we have in keeping our patients continent and our carpets odour-free.

The addition of carpets to an environment, already considered quite homely by virtue of other furnishings, completes the picture by changing the 'feel' and greatly reducing the rather bright, noisy quality so typical of many other uncarpeted institutions. The excellent domestic service does indeed play a vital role in maintaining the carpets in their present condition but I can assure Dr Jolley that this is not at the expense of the secretarial delays described by him.

Dr Jolley has visited a number of units which he feels support his anti-carpet philosophy. I urge him to widen his horizons, remove his noseplug and make haste to my service to be enlightened.

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MCQs in the MRCPsych

DEAR SIRS

The recent publication of four articles on MCQs in the MRCPsych (*Psychiatric Bulletin*, February 1991, **15**, 87, 88, 90 and 108) is to be applauded for providing some helpful guidelines on how to approach them and should be welcomed by trainees as the uncertainty of what awaits and is expected of them is a source of considerable anxiety. Such strategies as those suggested may help reduce the anxieties induced by this particular part of the exam and improve candidates' performance. The fact that candidates are obliged to pass the clinical examination and

that the short answers paper and clinical vignettes are more alien to the majority of medical graduates means similar attention to all aspects of the exam may well be profitable.

Obviously, there is no substitute for an adequate level of knowledge, which is presumably to be gained from studying the major post-graduate textbooks and selected key references. The Examiners state the MCQ content is derived from uncontentious material available to all trainees but do not detail these sources. A member of the Collegiate Trainees' Committee informed me that a member of the Examinations Committee had told him that all the relevant information could be gleaned from the *Edinburgh Companion*, the *Oxford Textbook*, Hildegard & Atkinson's *Psychology Test*, McGuffin's *Scientific Basis of Psychopathology* and the regularly updated *Current Opinion in Psychiatry*. The College would do well to substantiate or refute such rumours, perhaps by providing an authoritative exam reference syllabus.

Dr Smith's suggested study technique is an especially valuable contribution. As he says, reading textbooks and key references while thinking what MCQs could be derived from the material can alert one to potential questions and identify areas that probably cannot be examined in MCQs, that are perhaps more likely to be tested in other parts of the exam. It also provides a much needed novel way of revising and allows candidates to appreciate some of the difficulties facing Examiners. There is at least one MCQ book, that accompanies the *Edinburgh Companion*, that demonstrates this process.

As well as practising MCQs oneself, candidates can gain from doing so as part of a study group where the opportunity to discuss how others generally approach MCQs and answer specific questions can be very illuminating. Similar benefits can accrue from practising short answers, clinical vignettes and even the clinical examination in such a setting. A study group also provides some 'group supportive psychotherapy' in assuaging anxieties as the exams loom.

It is, of course, important to attempt past papers and a lot of people find MCQ tests invaluable. There is a glut of these on the market so people can afford to be selective about which one to use. Ideally, such a test should provide one with a detailed explanation of an MCQ answer, preferably with a reference. Those texts that merely give questions and a true/false answer give little information on how to approach them while further depleting financial resources at a time when many can ill afford it! Finally, there is at least one drug company (Dista) that can offer computerised MCQ experience if requested.

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DEAR SIRS

I read Bisson's article on the MCQ (*Psychiatric Bulletin*, February 1991, **15**, 90–91) with a sense of *déjà vu*. He described exactly my irritation when I took it. My own method was to answer the questions on the basis of how I thought the then Chief Examiner would answer them: on at least two questions on defence mechanisms and ethanol-induced brain damage this resulted in a different answer to the one I actually thought was correct.

Since I passed, this must not have been a totally erroneous strategy. Perhaps MCQs do not test what you know but who you know?

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Soviet psychiatry

DEAR SIRS

Over 18 months have elapsed since the decision of the Athens Congress to re-admit Soviet psychiatrists to the WPA (Bloch, 1990). It appears that psychiatric abuse in the Soviet Union has been ameliorated but not eliminated. Most 'political' patients have been discharged and a million names have been removed from the Psychiatric Register. The Supreme Soviet imposed regulations on psychiatric treatment in 1988, making wrongful detention a criminal offence. Responsibility for the infamous high-security SPHs has been transferred from the Ministry of Internal Affairs to the Ministry of Health. Psychiatric abuse has been openly criticised in the Soviet media, and the authorities have shown a noticeable willingness to allow dialogue with foreign psychiatrists.

Optimism over recent improvements must be tempered by scepticism, as Koryagin (1990a) insists. Structural changes have been limited and, despite overtures to the contrary in Athens, leading Soviet psychiatrists continue to deny that any abuse ever took place. Though lower in public profile, those senior psychiatrists most closely identified with 'political psychiatry' have yet to be displaced from office and hinder further progress.

Unlike its neighbours in Western Europe, Russia was transformed from a largely feudal to a Socialist command economy in the years after 1917, without the development of capitalism or the establishment of liberal democratic structures enshrining the rights of the individual in law. The question of civil liberties in the USSR remains vexed, with obvious consequences for any attempt to redefine the limits to compulsory treatment (Koryagin, 1990b).

Although Soviet psychiatry was cynically abused for political purposes over many years, outrage must be qualified by knowledge of the relatively small scale on which this took place and the brutality of earlier means of repression. The history of the USSR this