If a junior attempts to avoid a bed crisis by sending home patients for whom in-patient care is indicated and the consultant responsible is not made aware, this distorts the pressure on the service perceived by consultants and managers. It could be postulated that such action by juniors creates an impression of a reduced requirement for beds thus facilitating further mismatch between need and service.

I do not even agree that it is part of the job of a junior doctor to know the bed state. If the decision has been made by a junior to admit a patient then surely it is the job of a designated bed manager to find a bed. If no beds are available then the duty consultant should be asked for advice. It is down to the junior to resist taking responsibility for risky decisions and to pass it back to those with more experience.

MICHAEL SHAW, *Leighton Hospital, Middlewich Road, Crewe CW1 4QJ*

Sir: In response to Frances Foster (*Psychiatric Bulletin*, June 1994, **18**, 371–372) I agree that the current bed shortage throughout the country is cause for concern, not least with junior medical staff.

In addition to the consultant psychiatrist taking fewer risks and delaying discharge, in my experience this has now extended to the Mental Health Review Tribunal who appear increasingly cautious with regard to discharging patients from hospital. This too is exacerbated by lack of finances and facilities available to the social services in the community.

Indeed, despite the policy of closure of many large psychiatric institutions, and even further reduction in the number of available hospital beds and increasing emphasis on community care, the pendulum has begun to swing in the opposite direction. More in-patient facilities will inevitably be needed in the future to accommodate the increasing caution within the field of psychiatry unless this trend ceases.

STEPHEN NOBLETT, *Fazakerley Hospital, Liverpool L9 7AL*

Sir: We read with interest the letter from Dr Foster concerning bed shortages (*Psychiatric Bulletin*, June 1994, **18**, 371–372). Acute psychiatric beds are becoming an increasingly scarce and precious resource.

We disagree that a reluctance by consultants to discharge patients is the prime cause of such a shortage. There are many other causative factors. Bed closures, inadequate community resources and time spent finding accommodation for the difficult to place chronically mentally ill, combined with a failure to acknowledge their long-term needs, must all play a part.

We agree that bed scarcity does place extra pressures on junior staff, particularly when they are on call. We also experience recurring difficulty in finding vacant beds for patients. This necessitates the risky use of leave beds and even the emergency placement of relatively young patients on psychogeriatric wards. The decision whether or not to admit patients is inevitably influenced by the bed state. Even before assessing patients in the accident and emergency department there can be pressure not to admit them to hospital because of bed shortages and to depend instead on community resources, however inadequate and inappropriate they may be. Risk taking is inevitably devolved to junior staff.

We agree with Turner (*Psychiatric Bulletin*, 1994, June, **18**, 371) that the Mental Health Act does not create an incentive for discharge. The use of acute psychiatric beds for detained or informal patients, while waiting community resources to be identified and funded, is in our view an inappropriate but recurring use of an increasingly scarce resource.

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Mental Health Review Tribunals

Sir: We read with interest the correspondence by Green & Wallis (*Psychiatric Bulletin*, June 1994, **18**, 374) and Wood (*Psychiatric Bulletin*, June 1994, **18**, 375) regarding attendance of the Responsible Medical Officer at Mental Health Review Tribunals.

The tribunals should not be used to 'pass the buck'. However, the circumstances in which the RMO may be seen to be doing so vary. For patients detained under section 2, there is very little time between detention under the Act, applying to the tribunal, the RMO's appraisal and hearing by the tribunal and it would be unwise for the RMO to revoke the Order before the tribunal hearing unless the patient is 'cured' in that short period.

The difficulty arises with patients detained under section 3 and 37 of the Act. The RMO should not wait for an application or a reference to the tribunal to be made before considering the patient's discharge and this should be seriously considered at the time of the renewal of detention, endorsed by hospital managers. One of us (AK) attended 47 tribunals for patients detained under section 3 and 37 under his care over the past four years, not recommending a single discharge and the recommendations were upheld in each case.

The experience of Green & Wallis cannot be generalised to most psychiatric hospitals because of their highly selective patient group

(being a private hospital) where often the most difficult patients are admitted.

The situation with restricted patients is different. The RMO has no authority to discharge the patient, although the Home Office could be accused of passing the buck. It is unfair that administrative officers and clerks, hundreds of miles away at the Home Office, should make this decision for some of the most difficult, complicated and dangerous patients. In our experience, the Home Office delegates this responsibility to consider and order conditional discharge of a restricted patient to the tribunal. Once again, one of us (AK) has experienced a 100% concordance in his view as the RMO and the tribunal decision. Over the past four years, 15 tribunals were held for restricted patients under his care and in six cases a conditional discharge was recommended and granted.

With regard to the attendance of the RMO at tribunals, we agree with Wood that the RMO should be available to give evidence. The tribunal dates are fixed after negotiation and agreement with the RMO who should not delegate this responsibility to juniors. Attendance at the tribunals by junior doctors as observers is a valuable experience. For unrestricted patients, junior doctors may be asked to write psychiatric reports for the tribunal (under supervision) and give verbal evidence. But the RMOs should make themselves available if the tribunal wishes to consult the RMO on issues where only a RMO can make a decision.

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Propofol and electroconvulsive therapy

The finding by Bentham & Callinan (*Psychiatric Bulletin*, June 1994 **18,** 374) of an association between propofol and a higher number of shorter seizures compared with methohexitone is not surprising. It is now well established that propofol should not be used for ECT. Although it has many good features such as smooth induction of anaesthesia and rapid and complete recovery, its potential to reduce seizure activity contraindicates its use for ECT (Simpson *et al*, 1988). Methohexitone is the agent of choice, in a dose of 0.75–1.0 mg/kg but at higher doses it also decreases seizure length (Miller *et al*, 1985). It is therefore not sufficient simply to advise that propofol should not be used with the implication that methohexitone is devoid of any problems. In addition, the degree of oxygenation/ventilation, the type of psychoactive drugs that are prescribed and other factors such as age and gender, all need to be borne in mind when assessing a patient who has had short/unsatisfactory seizures during ECT.

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SIMPSON, K.H., HALSALL, P.J., CARR, C.M.E. & STEWART, K.G. (1988) Propofol reduces seizure duration in patients having anaesthesia for ECT. *British Journal of Anaesthesia*, **61,** 343–344.

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Parental suicide

Sir: The article by A. Ubeysekara (*Psychiatric Bulletin*, June 1994, **18,** 340–342) highlights the importance of preventive work for bereaved families but does not mention a role for adult psychiatrists. Most psychiatrists will have patients who are also parents and who commit suicide. Parental suicide has been shown to relate to subsequent bereavement (Shepherd & Barraclough, 1976) and parental suicidal tendencies to suicidal ideas in a non-clinical sample of children (Pfeffer *et al*, 1984). Adult psychiatrists need to consider such patients in the context of their families (Kissane & Bloch, 1994) and arrange early appropriate intervention. The model suggested in the article may be useful in deciding on these interventions.

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Psychotherapy training in Turkey

Sir: We would like to expand on some issues concerning psychotherapy training which was briefly referred to by Samanci & Erkmen in their article 'Psychiatry in Turkey' (*Psychiatric Bulletin*, May 1994, **18,** 300–301).

Just as Anatolia, or ancient Turkey, was the motherland that gave birth to many civilisations, it was also one of the main regions where the art of medicine was skilfully practised and promoted. The Anatolians were concerned about mental illnesses and their treatments. For example, in the renowned hospital of the Asklepion