given a Grade D in the re-grading which compares unfavourably with their colleagues working on the in-patient unit. In common with many day hospitals, our nurses exhibit a high degree of clinical autonomy and are responsible for a substantial caseload of community based patients. They must liaise with families, community carers and the psychiatric firms to which the patients are attached. In addition they are responsible, with other members of the multidisciplinary team, for developing care plans for their patients, and ensuring that these plans are executed, and take a large part in maintaining the therapeutic programme of the day hospital. Since the majority of our patients have long-term disabilities our staff nurses often have to maintain contact with patients over many years.

This work contrasts sharply with the tasks of a staff nurse on an in-patient unit, arguably requiring a much higher degree of professionalism than is generally found among nurses who have not yet left the security of the hospital in-patient base.

I would be interested to know from colleagues whether they too have discovered anomalies in the grading of the nurses with whom they work and what, if anything, they have been able to do to remedy the situation. There is no doubt that if, in my unit, the grading is unchanged we shall be unable to retain and recruit staff. This will of course suit management, desperate to save money, but is hardly designed to encourage policies of community care.

FRANK HOLLOWAY

St Giles' Hospital
St Giles' Road
London SE5

Mental Health Review Tribunals

DEAR SIRS

Dr Heaton-Ward's comments (*Bulletin*, August 1988) are very timely and warrant serious consideration by the College. An open-necked shirt and a casual, almost indifferent, attitude may be thought to put the patient at ease and may be the extreme, but they do not inspire confidence in the Tribunal's members. On more than one occasion I have felt embarrassed that I belonged to the same profession.

Tribunal offices obviously have problems in arranging hearings for Section 2 cases in view of the limited time available and it is accepted that the RMO may be unable to be present, but it would be helpful if a junior medical officer could represent the RMO rather than leave that responsibility to the ward sister or charge nurse.

I have sometimes found the RMO's report to be less informative and of less assistance than that of the social worker and I think the College has a responsibility to ensure that the standards of our profession are maintained and the interests of the patients protected.

The RMO is at liberty to ask the Tribunal President if a junior MO may attend the hearing as an observer, as part of training, and, to the best of my knowledge, such a request is always granted.

A. H. D. HUNTER

4 Springfield
Littleover, Derby

Guidelines for the training of general psychiatrists in liaison psychiatry

DEAR SIRS

I was interested to see that assessing deliberate self harm and patients in the Accident and Emergency Department are seen as part of the job description of liaison psychiatry (*Bulletin*, September 1988).

I have always felt that as psychiatric services become more community orientated and develop a more adequate response to emergencies outside the hospital, this emergency service should also cover the Casualty Department and deliberate self harm. In both cases the patient has usually come to attention because of problems outside the hospital and the skills involved in assessment and management seem to me rather different than those involved in assessing the psychiatric problems surrounding physical illness.

SAM BAXTER

Charing Cross Hospital (Fulham)
London W6