that, in fact, he was suffering from adult attention–deficit disorder – on the grounds of his combination of restless overactivity and grossly impaired attention, with disinhibition in social relationships, impulsive flouting of social rules and constant interruptions during any form of conversation.

The patient's antipsychotic medication was stopped and he was commenced on a trial of methylphenidate within dose guidelines of 0.6–1.01 mg/kg. When his daily dose reached a stable level of 80 mg daily, his attention span increased markedly over a period of about a week. He became less disruptive within the locked ward environment where he had been managed for some months and realistic plans for his graded return to the family environment were entailed. Family illness had slowed this process down and we were hoping for an agreement for a discharge from Section deferred for one to two weeks.

Unfortunately, after hearing the answers to the initial statutory questions on diagnosis, the tribunal adjourned immediately and subsequently was unwilling to hear further evidence on the progress of treatment and social circumstances. The tribunal felt obliged to recommend that the patient concerned was illegally detained because the diagnosis was not a recognised mental disorder in Britain.

Informally, the tribunal members told me that, as an unwritten rule of thumb, the ICD–10 (World Health Organization, 1992) is used as guidance on whether a disorder or diagnosis constitutes a mental disorder or mental illness within the meaning of Section 1 of the Mental Health Act. Reference in ICD–10 to adult attention–deficit disorder is in the chapter on disorders of childhood and adolescence, coded under F90.

Increasingly, adult attention–deficit disorder is recognised within the world literature as an entity which adult psychiatrists will be called upon to treat (Biederman *et al*, 1993; Mannuzza *et al*, 1998). The concept has a lot of face validity and, given the disruptive nature of the behaviour, it is inevitable that patients with this diagnosis will appear before Mental Health Act review tribunals with increasing frequency. It would be extremely worrying if the events described above were to be replicated across the country as there are many circumstances where it would be very difficult to treat the more severe forms of this disorder on a purely voluntary basis.

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Exam results in the 21st century

Sir: The Royal College of Psychiatrists continues to publish exam results through a list of successful candidates pinned to a noticeboard in the College. A duplicate list is put up in Edinburgh and candidates are sent their results by post the day before (with the usual variation, therefore, in when they actually receive the same). Many rotations organise interviews on or about the date of these results. In order, for example, to be able to calculate the number of Senior House Officer/Level 1 posts available the interview panel needs to know how many existing trainees have passed their Part 1 Examination. This is inevitably competition for applicants and those schemes which interview closest to the date of the results are more likely to be in a position to appoint the best candidates.

We suggest that this present method of publishing examination results by the College is unsatisfactory from all points of view. The process is neither fully public nor private and falls uneasily and inefficiently between the two. The fact that London-based schemes are able to acquire the information they require with relative ease compared with other parts of the country also does little to counter the charge of a 'London bias' which the College is accused of by many (although perhaps this should be a 'Capital bias' given the above).

Surely it would be better if, in common with other Royal Colleges, ours was to avail itself of the opportunity to make effective and practical use of the Internet and publish examination results on its website. The Internet is becoming a commonplace tool used by clinicians in a variety of ways as recognised and supported, at least rhetorically, by the College itself and by the expectation that Internet access be available in all teaching centres.

Is the College going to grasp this nettle or are we going to be stuck with the drawing pins into the 21st century?

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Sir: For many years the College has published a list of successful candidates for both parts of the Examination by posting a pass list on noticeboards at the College in London and at its divisional offices in Edinburgh, Dublin and Cardiff. Dr Allen *et al* are certainly not alone in producing convincing arguments as to why this is not satisfactory for trainees or College tutors, and particularly for those located some distance from the College's offices.

I have been very keen, since my appointment a year ago, to develop the use of the College website to widen access to information about the examination regulations and syllabus, the application process and the publication of results. I am very pleased to report that all of this information is now available on the College website, and from Autumn 1999 the MRCPsych Examination pass lists will also be published on the website on the same day that results are posted to candidates. The results will continue to be displayed in the College and its divisional offices for those who find this the most convenient point of access.

I am aware that there are further developments which should be possible in our use of the Internet, but I hope that you will find what has been achieved so far as a major improvement in the service we provide.

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Comments on psycho-oncology

Sir: Montgomery (*Psychiatric Bulletin*, July 1999, **23**, 431–435) has written a comprehensive and useful summary of the recent development, present state and future challenges of psycho-oncology. I wish to make just three comments.

In a recent study by Watson *et al* (1999) of 578 patients with early breast cancer, the association found by Greer (1979, 1990) between fighting spirit and a longer period of survival was not confirmed, although the association between depressive symptoms (as measured on the Hospital Anxiety and Depression Scale) and worse survival was. This is an important finding given the significance attributed to fighting spirit by many patients and their resultant anxiety if they think they do not have, but should have fighting spirit.

Montgomery mentions Spiegel *et al*'s (1989) finding that metastatic breast cancer patients randomly assigned to receive group therapy lived on average 18 months longer than the control patients. This has been challenged by Fox (1998) who pointed out that the treatment group did only as well as the national and local average while the control group died at a faster than average rate. This suggests a sampling error and casts doubt on the supposed positive effect on survival of this type of treatment.

A major problem for psycho-oncology remains the low esteem in which psychological treatments are held by oncologists and cancer surgeons. Underlying this is a dilapidated Cartesian dualism, that is the view that mind and body are two very different substances, so different in fact that an interaction between the two can hardly even be conceptualised. Psycho-oncologists, for their part, have failed to suggest an alternative model – or even to show any interest in the problem.

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Stigmatisation of psychiatric disorder

Sir: Stephen Lawrie (*Psychiatric Bulletin*, March 1999, **23**, 129–131) described many of the effects of stigmatisation in people suffering from psychiatric disorders. I would like to add another dimension; the discrimination of psychiatric patients in obtaining adequate physical care.

As a registrar, I was once asked to see a known patient, suffering from schizophrenia and 'hearing voices' in casualty. I asked what had brought him into hospital and he described a severe chest pain. I checked the casualty card on which was simply written "hearing voices→refer psyche". After further investigation, it became apparent that his only concern was his chest pain and that the hallucinations were incidental, chronic and not bothering him in any way. No physical examination or electrocardiogram had been

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