Currently, this may appear to disadvantage UK doctors, who have to undergo longer training than their European counterparts. The Calman Report addressed this issue by proposing improvements to training that will mean that it is shorter and more structured, while not affecting quality standards (Kisely, 1993).

Content of training will remain the prerogative of the competent body in every member state. In the UK this will be the Royal College of Psychiatrists. There is no question of UK trainees having to learn about neurology or *la bouffee delirante*, unless they wish to.

In addition, there is no reason why the introduction of a unified training grade and shorter training would mean the end of psychiatric subspecialties. In Australia and New Zealand, where training in a unified grade lasts only five years, their college has sections for child psychiatry, alcohol and other drugs, forensic psychiatry, psychiatry of old age, psychotherapy, and social & cultural psychiatry. If anything, training in Australia is more comprehensive, in that exposure to child and liaison psychiatry is obligatory.

I happen to enjoy research, having just completed one academic job, and starting another later this year, but many trainees wish to concentrate on clinical, teaching or administrative duties. There has been an over-emphasis on the requirement for research in medicine in this country. Experience in research should be available for everyone who is interested, not as a means of filling in time while awaiting a consultant post.

There are very real dangers to training and the speciality with the advent of the changes envisaged by the Calman Report, but not the loss of subspecialities or research opportunities. If the government persists in implementing change without additional funds for greater numbers of consultants, career opportunities may well worsen. Loss of training opportunities, or pay, are far more likely to arise out of the government's reforms of the health service. Additionally, training and pay may be influenced by the opportunities for Trusts to employ doctors without regard to national terms and conditions of service or manpower restrictions.

KISELY, S.R. (1993) The future of psychiatric training after the Calman Report. *Psychiatric Bulletin*, **17**, 610–612.

STEVE KISELY, *Northamptonshire Health Authority, Highfield Road, Cliftonville Road, Northampton NN1 5DN*

We cannot look into the future. That is the main reason why we have spoken of *likely* consequences of Euro-harmonisation for psychiatric training (*Psychiatric Bulletin*, April 1994, **18**, 193–195). It is unclear to us how it is possible for Dr Kisely to state that our conclusions do not accord with the facts. Which facts? The process of harmonisation is only in its earliest stages and, as far as we are aware, Calman's recommendations have not been implemented yet in psychiatric training. We suspect that Dr Kisely is creating his own argument, disregarding one of the very few hard facts in this discussion; according to the Calman Report (p. 33), training will have to be shortened by one to three years to a maximum of five to six years. A simple calculation teaches us that, if the duration of subspecialty training were to remain at its present duration (four years), one to two years will be left for general psychiatric training. As this is unlikely to be acceptable we expect that the only option will be to shorten subspecialty training. A similar arithmetic is applicable, *mutatis mutandis*, to time spent in research. *Quod erat demonstradum*!

JAN NEELEMAN and JIM VAN OS, *The Maudsley Hospital and the Institute of Psychiatry, Denmark Hill, London SE5 8AZ*

Ethical dilemmas in drug treatments

Sir: While the case described by Tyrer and commented upon by Smith & Adshead (*Psychiatric Bulletin*, April 1994, **18**, 203–204) would appear to represent a commendably flexible interpretation of the doctor/patient contract, I fear that due to other factors, such an approach is increasingly likely to be impractical and for the responsible medical officer, dangerous.

Coid (1994) has summarised the increasingly alarming position in which psychiatrists are being placed in terms of their accountability for the acts of their patients and it seems quite clear that if Tyrer's patient were to behave violently and cause harm to someone, then Tyrer would be held accountable for this and possibly face disciplinary proceedings.

The dilemma, I would suggest, is not so much between professional standards and patients' freedom but now between professional survival and that freedom.

COID, J. (1994) Failure in community care: psychiatry's dilemma. *British Medical Journal*, **308**, 805–806.

D.R. DAVIES, *Tone Vale Hospital, Norton Fitzwarren, Taunton, Somerset TA4 1DB*

Sir: We are grateful to Dr Davies for his comments on our paper. While his views may appear somewhat alarmist, we would agree that in the present political climate doctors are vulnerable to being scapegoated when their patients behave dangerously. The newly introduced Supervision Register is a prime example of this. To what extent psychiatrists can be held liable for their patients' behaviour is unclear. We believe that

the profession needs to determine the scope of psychiatrists' responsibility before someone else decides for us. We would therefore urge the College to address this issue as a matter of urgency.

However, in the case we described, the management hinged on the fact that the patient was competent to make decisions about her treatment. The psychiatrist cannot over-ride her decision unless there are grounds for detention under the Mental Health Act and compulsory treatment.

JEANNETTE SMITH, *Fromeside Clinic, Blackberry Hill, Bristol BS16 1ED* and GWEN ADSHEAD, *Institute of Psychiatry, De Crespigny Park, London SE5 8AF*

Sir: When defensive practice becomes a replacement for good clinical practice our services become redundant. If Dr Davies and all my other colleagues support this maxim our professional survival is assured.

PETER TYRER, *St Charles' Hospital, London W10 6DZ*

Junior doctors and the drug management of disturbed behaviour

Sir: The survey by J.G. Cunnane (*Psychiatric Bulletin*, March 1994, **18**, 138–139) of consultant psychiatrists' opinions regarding drug management of acutely disturbed behaviour emphasised their lack of consensus, a fact which in itself is probably not surprisingly if the wide range of clinical scenarios and the myriad of available tranquillising medication is considered. However it was clear that chlorpromazine 100 mg intramuscularly was the most frequently advised treatment.

Both the *British National Formulary* (British Medical Association & Royal Pharmaceutical Society, 1993) and the data sheet for Largactil (in *ABPI Data Sheet Compendium*, 1993) state that the maximum i.m. dose for the relief of acute symptoms in an adult is 50 mg every 6–8 hours. The BNF does comment that "In some patients it is necessary to raise the dose of an antipsychotic drug above that which is normally recommended. This should be done with caution and under specialist supervision".

A recent document produced by the Royal College of Psychiatrists (1993) in response to disquiet regarding high dosages of antipsychotics states: "A junior trainee psychiatrist (SHO or registrar without MRCPsych) is not considered to be sufficiently qualified to take a decision to raise the dose of antipsychotics . . . above the recommended upper limit. This applies particularly in the emergency and acute situation . . .".

Immediate management of most acutely disturbed patients will be by such junior doctors, often out of hours, when there may be considerable need for swift and correct management decisions. They are clearly not considered to be specialists thus prescription of i.m. doses of chlorpromazine above 50 mg should not be made by juniors without the specific authority of a senior doctor. While this point may appear somewhat pedantic we practise in an increasingly litigious society and juniors who ignore such matters place themselves at risk. Much clearer emphasis should be made as to the utility of more potent neuroleptics such as droperidol and haloperidol when parenteral administration is required, as relatively much higher doses can be used when necessary.

ASSOCIATION OF THE BRITISH PHARMACEUTICAL INDUSTRY (1993) *ABPI Data sheet Compendium*, London: Datapharm Publications.

BRITISH MEDICAL ASSOCIATION & ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN (1993) *British National Formulary*, number 26, London: British Medical Association & The Pharmaceutical Press.

ROYAL COLLEGE OF PSYCHIATRISTS (1993) *Consensus Statement: the use of high dose antipsychotic medication.*

MARK MCCARTNEY, *Rampton Hospital, Retford, Nottinghamshire, DN2 0PD*

Sir: Dr McCartney's interpretation of this situation is substantially correct. In our document on high dose anti-psychotics we were concerned about junior doctors, who are not yet trained specialists, using doses of anti-psychotics in emergency situations above the suggested daily limits. We recommend auditing the practice of anti-psychotic prescribing in each psychiatric unit and suggest that appropriate policies are drawn up to ensure safety in the use of anti-psychotics.

CHRIS THOMPSON, *Chairman, Consensus Panel on the Use of High Dose Antipsychotic Medication*

Possible changes to the MRCPsych Part II examination

Sir: Having also recently sat MRCPsych Part II examination, I would like to comment on Dr Akinkunmi's letter (*Psychiatric Bulletin*, March 1994, **18**, 175). His proposal is to separate the written and oral/clinical part of the exam so that a candidate will be allowed to enter the second part only when there is a realistic possibility of passing the whole examination – like the MRCP. Each will be paid for by separate cheques and the 'doomed' candidate spared additional stress and unnecessary expense. However, more time will be necessary between the two parts and the more fortunate candidates will have to bear a longer episode of stress.