to meet ordinary demands of life, or maintenance of adequate contact with reality.

In the light of this background, it was interesting how many respondents gave a simple, easily comprehensible statement of their understanding of the term. The most commonly cited item (disturbance of contact with reality) was distributed across all the professional groups except the DGH consultants and was considered sufficient to stand alone as a definition with no other items in almost half those who cited it. However, although the most common, it was in fact only cited by half the respondents. It constitutes one element of the ICD-9 definition and analysis for the inclusion of any of the ICD-9 elements revealed them in less than two-thirds of replies (31 of 51). Thus over a third of our respondents understood psychosis to mean something outside the ICD-9 definition, this group being proportionately distributed among the professions except among DGH consultants and social workers where two-thirds fell outside the ICD-9 classification.

This very limited study indicates that although there is some consensus about the meaning of psychosis within hospital psychiatry, this is not shared by workers outside psychiatry and the usefulness of the term should therefore be questioned. The discrepancy may be particularly important when psychiatrists are communicating with doctors in other areas of medicine or in discussion with approved social workers.

M. RAMELL

Wonford House Hospital
Wonford, Exeter
EX2 5AF

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Competitive psychiatry

DEAR SIRS

Paul Foster (*Psychiatric Bulletin*, August 1991, **15**, 509–510) has discovered the awful truth! Not only is psychiatry, like any other branch of medicine, competitive but in the post White Paper NHS all of us are going to be competing with each other at every level and with our colleagues in the multidisciplinary team for patients, resources and the renewal of our time limited contracts. We hope he recovers from the loss of idealism, because when he obtains a consultant post he will have to divert his energies from clinical matters to survival at the coalface – **management!** . . . courses to gain managerial skills and expertise, endless hours of meetings, volumes of minutes and reports to be read and even written, not to mention the accountancy, marketing and planning . . . the emperor's new clothes!

PARSLEY POWER-SMITH
JANE FALVEY

Royal Hallamshire Hospital
Glossop Road
Sheffield S10 2JF

Voluntary treatment – funding implications

DEAR SIRS

One consequence of the current development of purchaser/provider arrangement in psychiatry does not seem to have received much attention; that being a potentially marked increase of powers of detention and transfer of patients under 1983 Mental Health Act.

We recently encountered what must be a fairly common situation whereby a middle-aged man who had previously been treated at this hospital and who had since moved out of the health district, presented himself here requesting treatment. On examination, he was found to be suffering from a psychotic depressive illness and was at high risk of suicide, making hospital admission necessary. He was unwilling to be transferred to his catchment area hospital due to the mood congruent paranoid persecutory delusions which he held about that hospital. He was willing to stay in this hospital because he held no such delusions about us. We were then faced with a dilemma; should he be detained and transferred under Section to his catchment area hospital, or should he remain as a voluntary patient at this hospital despite the funding implications for his own health district? We decided that his right to voluntary treatment outweighed the funding implications and he received a satisfactory course of treatment and was discharged to follow up care from his catchment area hospital, and they will shortly be receiving a bill from us. We would be interested to know if cases of this kind would be considered sympathetically by health-care purchasers across the country.

BARRY CHIPCHASE
D. MCGOVERN

Barnsley Hall Hospital
Stourbridge
Bromsgrove B61 0EX