DEAR SIRS

I was indeed delighted to read the paper 'A different reading list for the MRCPsych' (*Bulletin*, October 1986, **10**, 284). The 36 titles mentioned therein are simply superb. However, I cannot resist suggesting the following three additional titles: *The Loved Ones* (Evelyn Waugh), *Siddhartha* (Herman Hesse) and *The Day of the Jackal* (Frederick Forsyth).

I earnestly wish that trainees could add one book a year to their existing burden and derive further insight into the complexities of human behaviour.

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(This correspondence is now closed. *Eds.*)

ECT practice

DEAR SIRS

The College was widely praised for its initiative and courage in commissioning its ECT survey and for reporting its disturbing findings five years ago.[1] As a result there were much needed improvements in the facilities for giving the treatment and, at least for a time, in clinical practice and the training of doctors.

As doctors appointed by the Mental Health Act Commission to give second opinions under section 58 we visit many hospitals to approve ECT for detained patients. We have become increasingly worried to observe that many of the junior doctors, who administer most of the ECT, do so without adequate knowledge or training and with little grasp of the electrical and physiological principles involved or of how to use the equipment intelligently. Named consultants should, though too often it appears to be in name only, have responsibility for ensuring that ECT clinics are properly organised and that the doctors are properly trained. Sometimes this training is wrongly left to the anaesthetist.

The Constant Current equipment now in general use requires more careful attention, than the older Constant Voltage apparatus, to such details as skin contacts and control settings if the stimulus is not to be so close to the seizure threshold that the treatment is 'missed' or relatively ineffective. Controls are often set, by clinic custom, at a level which is not changed even if the patient does not convulse; there may be no guidance on what to do if this happens.

ECT treatment recording schedules all too often include doses of atropine, anaesthetic agent and muscle relaxant and perhaps the time duration of the stimulus used from the Constant Current apparatus, but omit to state whether the ECT 1 or 2 switch position was used in the case of the Duopulse model and, more disturbingly, whether a discernable convulsion was produced or not.

We are encountering some patients with psychotic depression where a considerable number of ECTs have been given but expected improvement has not occurred and where the ECT treatment card does not record whether convulsions have occurred or not. Members of the College must surely not let themselves drift back into the complacency towards their ECT practice which the survey revealed and which, sadly, is again becoming apparent.

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REFERENCE

[1] PIPPARD, J. & ELLAM, L. (1981) *Electroconvulsive Treatment in Great Britain 1980*. London: Gaskell (Royal College of Psychiatrists)

Medical insurance

DEAR SIRS

I write to urge the College most urgently to press for some change in the current system of payment of professional medical insurance.

I am a part time senior registrar with young children. The greater part of my salary is absorbed by paying our Nanny. This, of course, I accept without question, (although I would remind you that women are given no tax relief on such payments). The second greatest expense is professional medical insurance. This I do most definitely resent.

After all expenses are paid, my resulting 'salary' is the princely sum of 65p per hour. We pay our cleaning lady at four time this rate.

Salary per annum (after tax)		£4,560.00
Essential expenses		
Medical Defence Union	£554.00	
Royal College of Psychiatrists	80.00	
General Medical Council	20.00	
Car expenses to/from work	250.00	
Child minding expenses	2,860.00	
Net income		£796.00

OR

£61.00 per month;
£13.00 per week;
0.65p per hour!

I feel truly privileged that I have work which I enjoy so much and do not expect vast payments. However, if current trends continue, I shall soon, in real terms, be earning nothing. My dedication is not so great that I would be willing to do this.

I feel I have more ability and certainly more personal rewards in continuing to be a doctor but perhaps I should be considering a career in domestic service?

Psychiatry, like other less popular specialities, relies on

women who work part time to provide an important part of the service. Is the College prepared to risk losing these women? The risk is real.

May I suggest either:

(a) Professional medical insurance is rated according to risk (psychiatrists are a low risk group); or (b) fees are related to time at work. (Those who work half time are surely half as likely to be sued as those who work full time).

It is normal practice amongst employers to pay their employees' professional insurance. Nurses' insurance is paid for them but not doctors'. Surely an iniquitous situation.

Finally the College could itself set an example of understanding for its women members and lower our current annual membership fee. Modelling is, after all, a potent method of altering behaviour.

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Psychiatric services for the mentally handicapped

DEAR SIRS

I welcome the article 'Psychiatric Services for Mentally Handicapped Adults and Young People' (*Bulletin*, November 1986, **10**, 321–322). Although it is slightly delayed, nevertheless, I hope that it will clarify the confused planning that has been occurring at both District and Regional levels.

In the past, it was assumed that all mentally handicapped people (irrespective of their mental disturbances and behavioural disorders) could be resettled in small group homes supervised by community teams and that all mental handicap hospitals could be closed, thereby saving millions of pounds. In practice, however, this has proved impossible and not to be in the best interests of mentally handicapped people. Re-admission to hospital has occurred in many cases, to the bemusement of the planners, thereby indicating a fault in their policy and bringing about a great wastage of money.

This article recognises the need for base hospital facilities in each Health District where it will be possible to provide a 'specialised psychiatric service for mentally handicapped people' as and when necessary. It has been estimated that 0.25 beds per 1,000 populace would be required for each District.

There has been a dichotomy in planning between the DHSS and the Royal College of Psychiatrists which has resulted in tremendous confusion at Regional and District levels which has impeded resettlement programmes. I only hope that the DHSS will now accept the practicality of the Royal College of Psychiatrists' planning and issue an urgent directive to planners at Regional and District levels to modify their plans for psychiatric services for mentally handicapped people as suggested in the article.

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Prescription charges

DEAR SIRS

We believe that the present system of prescription charges works to the disadvantage of many psychiatric patients and that pressure from professional and patient groups should be applied to effect immediate changes.

First, it is prudent clinical practice to provide potentially suicidal patients with short-term prescriptions, perhaps lasting only a few days. But each one must be paid for: there is a financial cost to thoughts of self-harm.

Second, there are many patients who require an additional drug to counteract the side-effects of their original prescription, e.g. anticholinergics with major tranquillisers. In effect they pay double because of the inadequacy of the first treatment. The same can be said of those who require two separate drugs to treat one disorder or those whose drug is rapidly switched because of lack of effect or unacceptable toxicity.

Third, there are some patients, such as those taking lithium, who require long-term maintenance therapy but who, unlike diabetics requiring insulin, must pay throughout their treatment.

The fact that a number of psychiatric patients are unable to find work and are consequently exempt from prescription payments should not obscure the unjust treatment of the others. Nor should our concentration on these specific failings imply support for the charge system in general: it is illogical in practice and inhumane in concept. Nevertheless there is no sign of its abolition. Clinicians must demand, therefore, that it operates fairly and push for necessary changes.

We suggest that the Royal College of Psychiatrists should request a revision of the payment system establishing (1) payment per course of treatment, irrespective of the number of drugs used and antidotes required or how frequently they must be dispensed because of, for example, a patient's suicidal urges; (2) exemption from payment of any patient on maintenance therapy, whether lithium, neuroleptics or antidepressants.

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Closure of large mental hospitals

DEAR SIRS

The closing down of the large mental hospitals is resulting in the fragmentation of psychiatric service into small units on district general hospital sites, or stuck out on their own. While this has obvious advantages for patients and relatives not having to travel very far, it does have adverse implications for junior psychiatrists working in these units. They will be finding themselves working mainly with other disciplines with very little chance of day to day peer contact, with the eventual loss of the very important process of peer learning.