(being a private hospital) where often the most difficult patients are admitted.

The situation with restricted patients is different. The RMO has no authority to discharge the patient, although the Home Office could be accused of passing the buck. It is unfair that administrative officers and clerks, hundreds of miles away at the Home Office, should make this decision for some of the most difficult, complicated and dangerous patients. In our experience, the Home Office delegates this responsibility to consider and order conditional discharge of a restricted patient to the tribunal. Once again, one of us (AK) has experienced a 100% concordance in his view as the RMO and the tribunal decision. Over the past four years, 15 tribunals were held for restricted patients under his care and in six cases a conditional discharge was recommended and granted.

With regard to the attendance of the RMO at tribunals, we agree with Wood that the RMO should be available to give evidence. The tribunal dates are fixed after negotiation and agreement with the RMO who should not delegate this responsibility to juniors. Attendance at the tribunals by junior doctors as observers is a valuable experience. For unrestricted patients, junior doctors may be asked to write psychiatric reports for the tribunal (under supervision) and give verbal evidence. But the RMOs should make themselves available if the tribunal wishes to consult the RMO on issues where only a RMO can make a decision.

MEENA AGARWAL, *Queen Elizabeth Hospital, Gateshead, Tyne & Wear, NE9 6SX* and *ANIL KUMAR, *Calderstones Hospital, Whalley, Clitheroe, BB7 9PE*

*Correspondence

Propofol and electroconvulsive therapy

The finding by Bentham & Callinan (*Psychiatric Bulletin*, June 1994 **18**, 374) of an association between propofol and a higher number of shorter seizures compared with methohexitone is not surprising. It is now well established that propofol should not be used for ECT. Although it has many good features such as smooth induction of anaesthesia and rapid and complete recovery, its potential to reduce seizure activity contraindicates its use for ECT (Simpson *et al*, 1988). Methohexitone is the agent of choice, in a dose of 0.75–1.0 mg/kg but at higher doses it also decreases seizure length (Miller *et al*, 1985). It is therefore not sufficient simply to advise that propofol should not be used with the implication that methohexitone is devoid of any problems. In addition, the degree of oxygenation/ventilation, the type of psychoactive drugs that are prescribed and other factors such as age and gender, all need to be borne in mind when assessing a patient who has had short/unsatisfactory seizures during ECT.

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S. CURRAN, *St James's University Hospital, Leeds LS9 7TI*

Parental suicide

Sir: The article by A. Ubeysekara (*Psychiatric Bulletin*, June 1994, **18**, 340–342) highlights the importance of preventive work for bereaved families but does not mention a role for adult psychiatrists. Most psychiatrists will have patients who are also parents and who commit suicide. Parental suicide has been shown to relate to subsequent bereavement (Shepherd & Barraclough, 1976) and parental suicidal tendencies to suicidal ideas in a non-clinical sample of children (Pfeffer *et al*, 1984). Adult psychiatrists need to consider such patients in the context of their families (Kissane & Bloch, 1994) and arrange early appropriate intervention. The model suggested in the article may be useful in deciding on these interventions.

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T. MORRIS, *Hesketh Centre, Southport, Merseyside*

Psychotherapy training in Turkey

Sir: We would like to expand on some issues concerning psychotherapy training which was briefly referred to by Samanci & Erkmen in their article 'Psychiatry in Turkey' (*Psychiatric Bulletin*, May 1994, **18**, 300–301).

Just as Anatolia, or ancient Turkey, was the motherland that gave birth to many civilisations, it was also one of the main regions where the art of medicine was skilfully practised and promoted. The Anatolians were concerned about mental illnesses and their treatments. For example, in the renowned hospital of the Asklepion

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