The chairman of the committee is able to take matters on board which have not been sorted at a local level. There can be direct communication with the Pan Rotational tutors, and problems can also be taken to the British Post Graduate Medical Federation Meetings, which the chairman attends.

There is also a social side to the activities, with regular rotational meals, generally sponsored by a drug company, and a recent jazz evening, which was open to all trainees and all consultant supervisors on the rotation.

One of the main difficulties encountered in this region is communicating effectively with each trainee. With the mailing list for the junior doctors' committee meetings being approximately 120 individuals, and the lack of designated secretarial support to the committee, this places a great strain on the individuals responsible for mailing. The idea of a newsletter and a logo which is in use in Liverpool seems very useful. However the experience provided to the committee members in administration and working with the every day politics of a training scheme are invaluable. Also the one day introductory course for new SHOs, which the chairman organises twice a year, the review of the end of placement assessment forms and the review of the logbook system used in South West Thames, have been important recent activities.

We would urge the setting up of junior doctor representation at all levels in other parts of the country, as the experience in South West Thames has been extremely profitable both to trainees and to their educational supervisors in improving the overall quality of trainee experience.

TOM MCCLINTOCK
Chairman, Junior Doctors' Committee
St George's Hospital Rotations

A trainee's view of hospital management

DEAR SIRS

The CTC (1990) has stressed the importance of management training for psychiatrists. As a registrar, it seems appropriate to record my impressions of hospital management before they are coloured by formal learning of management theory.

Junior doctors are privileged to occupy a unique niche in the hospital. We are closely involved with a variety of staff on a daily basis, but are not part of their management lines. This permits candid discussion, allowing us to accurately gauge staff feeling. "Manager-bashing" is a popular theme, and although this is hardly a new phenomenon, it is set against a background of low morale, resentment towards the ever-expanding management body, continual complaints of inadequate ward staffing levels, and high rates of staff sickness. Managers tend to be perceived as opponents who do not appreciate their staff, and who are interested only in administration, and not in patient care. Staff often do not feel they can trust their line managers enough to express their opinions honestly. This may or may not be the reality of the situation, but the sentiments themselves are very real.

So where is the system failing, to create such resentment? It appears that hospitals often focus on administrative issues to the exclusion of what must surely be the core of effective management; man management. Many managers seem to take for granted the staff under them. Either the principles of man management are not being adequately taught, or they are being ignored by hard-pressed managers. This must have implications for the training of psychiatrists in this area.

In making these, perhaps naive, generalisations, I myself have fallen into the obvious trap of manager-bashing, but I would stress that this is not aimed at specific individuals or hospitals. I am simply recounting what I and my peers regrettably see in many hospitals, and hope my comments may initiate constructive discussion, if only to prove me wrong. The currency of our business is patient care, and our greatest asset is our staff. If we look after them, surely we stand to gain better value for money in our ever-dwindling budgets?

M. R. ATKINS
Staffordshire

Reference

ROYAL COLLEGE OF PYSCHIATRISTS (1990) The CTC Working Party Report on Management Training. *Psychiatric Bulletin*, **14**, 373–377.

Familial thyroid disorder presenting as folie à deux

DEAR SIRS

I would like to draw your attention to a case of familial thyroid disorder which presented as a folie à deux or induced psychosis. There have been numerous case reports of folie à deux in the literature. The occurrence of psychosis in overactive and underactive thyroid disorders is also well documented.

Case history

Mr X, aged 20, has mild learning difficulties, and lives with his mother and stepfather. The mother and maternal grandfather have hypothyroidism. The mother is clinically myxoedematose. The patient was expelled from special school, aged 14, having threatened a teacher with a knife. He was prevented from leaving the family home by his mother for the ensuing three years. He was first seen by a psychiatrist from the community team for learning difficulties when aged 17.

Mother and son presented as suspicious and hostile. They shared the delusion that people wanted to harm them and that there was a plot to remove the son from the home. They both demonstrated a fear of eating in public as they believed the food would be poisoned. It was concluded that until the two could be separated, Mr X's mental state would not improve. Eventually the patient began attending a day centre. He remained suspicious and failed to engage. He was observed to be extremely restless. He was finally persuaded to have thyroid function tests.

In conjunction with the physical findings, the results revealed Mr X to be in thyrotoxic crisis. T4 = 89.4 (n 10–29), T3 = 35.0 (n 4.4–8.8), TSH = < 0.1 (n 0.3–4.0)

The chest x-ray revealed massive cardiomegaly.

Mr X responded well to standard treatment of thyrotoxic crisis. Lasègue & Falret were the first to describe folie à deux in 1877. They reported that "In folie à deux, one individual is the active element; being more intelligent than the other he creates the delusion and gradually imposes it upon the second or passive one". In the case presented it appears that both Mr X and his mother were psychotic as a result of thyroid disorder; many of the delusions were then shared. The mother being more intelligent, initially appeared to be creating the delusions for her "passive" son (induced psychosis), however once the diagnosis of thyroid disorder in the son was made, it became apparent that this was a case of folie simultanée, and not folie à deux. It may therefore be advisable, to ensure that both members of an apparent folie à deux, within a family have their thyroid status checked. Are readers aware whether this has been reported previously?

JEANNETTE PHILLIPS

The Maudsley Hospital
London SE5 8AZ

Reference

LASÈGUE, D. & FALRET, J. (1877) La folie à deux ou folie communique. Translation of the original paper in *American Journal of Psychiatry*. October 1964, Supplement 121.

Psychiatric disorder and firearm ownership

DEAR SIRS

Mr C.M., a 37-year-old divorced man whose father had been diagnosed as suffering from Huntington's Chorea three years earlier was referred for an opinion as to the appropriateness of his possession of a gun licence (for his shot-gun). He had been the only family member to take up the offer of pre-symptomatic testing and had been told he had a 95% risk of developing the disorder. He was at the time of assessment not exhibiting any abnormality of movement nor was any evidence of psychiatric disorder noted or complained of. He had been a regular gun user since his teens and stated his willingness both to cooperate fully with any followup recommended and to give up his gun at the first signs of illness. He was, however, extremely reluctant to consider giving up his gun until such signs appeared as it was his life's "only pleasure".

The case was discussed at a hospital case conference and it was noted that applicants for firearm licences had to disclose any criminal or psychiatric history they might have to the police, who supply such licences. In this case the patient had not as yet done so and both the patient's general practitioner and clinical geneticist had considered breaching medical confidentiality and informing the relevant authority. Such a breach was discussed at the case conference and felt to be an unfortunate, and potentially problematic, start to what was likely to be a long-term relationship between the patient and psychiatric services. The BMA's 'Firearms Guidance Notes' were found to recommend that if doctors "have reason to believe that an individual has access to firearms and is currently a danger to themselves or to society they should be prepared to breach confidence and inform the appropriate authorities (in this case the Chief Constable)". As in this case the patient was not considered to be dangerous currently, the consensus of the case conference was that it was not appropriate to breach confidentiality. The patient remains under regular follow-up, and his possession of a firearm under constant review. I would welcome readers' opinions on this situation or descriptions of similar problems relating to concurrence of psychiatric disorder and firearm ownership.

GARY HOSTY

Barnsley Hall Hospital
Bromsgrove
West Midlands

Statistical methods in audit

DEAR SIRS

Medical audit is seen as distinct from research in its purpose and its methods. We would like to make a report illustrating that the interpretation of audit data must be governed by the principles of statistics.

In our unit we observed an increase in the use of section 5(2) during a certain month when eight sections were applied. In the preceding six months the average rate had been 3.25. An audit was conducted regarding this "epidemic" but, applying a χ^2 test to the data set indicated that it could have been a chance finding ($P = 0.25$). Thus there was not necessarily an increase in the use of the section to form the basis for audit.