Correspondence

What puts medical students off psychiatry

DEAR SIRS

We read with interest the paper on what puts medical students off psychiatry (*Bulletin*, May 1986, **10**, 98–100) and wish to report a small study on career choices recently concluded at King's College Hospital Medical School, London. The study aimed to look at factors that militated against a continuing intention to specialise in psychiatry in students who had earlier expressed such an interest.

A cohort of 94 medical students were given an attitude-to-psychiatry questionnaire[1] which included questions regarding future career intentions. All students who expressed an intention of specialising in psychiatry at the end of their clinical curriculum were contacted at the end of their pre-registration year, and a further brief questionnaire was administered by post. This concerned their past intentions regarding a career in psychiatry and their current career intentions. In addition, those who had decided against a career in psychiatry were asked to complete nine five-point Likert-type scales regarding the influence of different factors on their decision. Each scale was anchored from 'strongly influenced'—1; to 'mildly influenced'—5. The questionnaire is available on request.

Of the 94 students in the cohort (58 males and 36 females), 14 (7 males and 7 females) expressed the intention of specialising in psychiatry at the end of their clinical curriculum. All 14 responded to the brief postal questionnaire. All except one of these students developed the intention to specialise in psychiatry after entering medical school, and the majority did so during or after the psychiatry clerkship. Only three remained 'definitely' interested in a psychiatric career at the end of the pre-registration year. Two reported that no decision at all had been made about their future speciality.

The factors influencing the 11 who had decided against specialising in psychiatry were ranked according to the median values of their grouped responses to each of the nine Likert-type scales. Among the factors influencing our respondents against specialising in psychiatry, the attraction of other specialities, professional experience of psychiatrists, and personal awareness of unsuitability seemed to be most important. The influence of psychiatric treatment methods and outcome, types of psychiatric patients seen in general medicine, and poor working conditions in psychiatry achieved middle rankings. Lack of career prospects in psychiatry and attitudes of family and close friends to psychiatry were ranked low.

From the long-term point of view it should be recognised that the developing pattern of mental health services, with increasing community care and greater involvement of general practitioners, indicates that the emphasis during undergraduate psychiatric training should be more and more on producing doctors in all specialities who are sensitive to their patients' psycho-social needs. Perhaps we should become less pre-occupied with the numbers specialising in psychiatry and concentrate instead on the quality of recruits.

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DEAR SIRS

I read with interest Jan Scott's well presented article on 'What puts Medical Students off Psychiatry?'. I think there is one important point that is not stressed.

Dr Scott mentions the overlap in interests between general practice and psychiatry but perhaps misses the point that it is the considerable financial improvement in general practitioners' earnings which has taken place in the last 12 years that has worked against recruitment in psychiatry.

It is quite true that what the psychiatrist has to offer the junior doctor is much more attractive now than it was 12 years ago and this could expect to increase recruitment to psychiatry, but it is the attractions, predominantly financial and particularly for rapid increase in earnings early in one's career, that has taken many recruits to general practice who might otherwise have come to psychiatry.

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ECT in the Netherlands and Britain

DEAR SIRS

In the June issue of the *Bulletin* (**10**, 155) there is a letter from two psychiatrists about the use of ECT in the Netherlands. In the period 1981–84, 35 non-geriatric patients had received a total of 38 courses of ECT.

In the Parliamentary News section, there is a report on the number of courses of ECT given in Britain. This may include geriatric patients, but the difference is considerable. In those same years, 1981–84, 81,185 courses of ECT were

given. Allowing for differences in population, say a factor of about 3 to 1, this is still a significant difference, and it should be possible to compare the rates of manic depressive psychoses and other illnesses for which ECT is routinely used in the two countries.

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Psychopathology of nuclear war

DEAR SIRS

I am pleased that Dr Ian Deary[1] has given such close attention to my article on 'The Psychopathology of Nuclear War'[2]. He makes numerous criticisms, many of which can be answered by pointing to your editorial wish to restrict articles to 2,000 words and to my own desire to keep to medical and psychological aspects of nuclear weapons, avoiding discussion of political choices.

Dr Deary found my article confusing but I'm afraid that I must make the same complaint about his. After spending much time defending the status quo of nuclear deterrence, he ends by advocating Steven Salter's scheme for slow multilateral disarmament[3]. His acceptance of the advisability of reducing the present numbers of nuclear weapons can only support my argument that nuclear deterrence has not been the safe and stable system which people have been led to believe it is.

I know Salter's scheme and agree that it is ingenious. But why is such a clever scheme not being used now? Because there is no real will to achieve reductions in nuclear weapons; because there is insufficient appreciation of the common threat which nuclear weapons pose.

Clever schemes in themselves will not provide this realisation and this will. I agree with Einstein in his declaration that "If mankind is to survive, we are in need of a fundamentally new way of thinking." Dr Deary tries to stretch old ways of thinking about war and weapons to fit the nuclear age, and in the end it doesn't hold together. He has to agree that more weapons mean more danger, not less. He also agrees that if nuclear deterrence fails once, it fails irredeemably.

His claim that a move to a non-nuclear defence policy would not release money for improving health and welfare is not true. It is quite possible to have a defence policy based on defensive, rather than retaliatory, deterrence at less cost than the present one[4]. Such a policy, unlike a nuclear one, is usable, credible and non-provocative and also more morally acceptable.

I agree with Dr Deary that spending on conventional arms worldwide is a much greater drain on resources than nuclear spending, but this is no argument for not starting to dismantle the most dangerous end of the weapons stockpile—its nuclear tip. It should then be easier to see others, e.g. the people of the Soviet Union, as human beings, making further disarmament moves more likely. Détente and nuclear deterrence can't coexist. You cannot get to know someone you have to pretend to be willing to incinerate.

Dr Deary makes the amazing statement that nuclear deterrence, with its constant threat of genocide, is "the crystallization of system wisdom". Wisdom is the last word which should be used. I prefer Profesor Bernard Lown's description[5], at the recent Cologne conference of International Physicians for the Prevention of Nuclear War, that "Deterrence is a suspended sentence of mass murder to be executed at any moment. The idea of pointing nuclear missiles at entire nations is without precedent in moral depravity."

Dr Deary finally complains that I make no proposal. Let me propose a necessary first step away from nuclear madness. I support IPPNW's call[5] for a moratorium on nuclear testing pending completion of a Comprehensive Test Ban Treaty. This would be the real litmus test of political will. It would not require trust, because seismological arrangements of verification are available. It would restore to people hope that nuclear weapons are within human agency to control, and enhance confidence between Governments. It would be an unprecedented achievement in preventive medicine.

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[3] SALTER, S. (1986) Stopping the arms race: a modest proposal. *Issues*, **II**, 74–82.

[4] PRINS, G. (ed) (1983) *Defended to Death*. Harmondsworth: Penguin Ch 10.

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Alcoholism and the Mental Health Act

DEAR SIRS

A letter from Dr Iqbal Singh (*Bulletin*, July 1986, **10**, 188) following an earlier letter of mine (*Bulletin*, February 1986, **10**, 38), in which he states that the best way of dealing with delirium tremens is to admit the person to a medical facility under Common Law, warrants a further comment.

I have some sympathy with the idea although I have not always been able to persuade my medical colleagues of the wisdom of such a move. The case over which I was in correspondence with the Medical Defence Union, however, could not be dealt with by this means. The patient, a woman in her late 30s, was already in hospital on an orthopaedic ward. On the day before I saw her, while intoxicated, she had sustained complicated fractures to her left tibia and fibula. Plaster of Paris had been applied but was not yet steady enough to bear weight. The symptoms of delirium tremens supervened and the patient attempted to run, or at least hobble quickly, out of the ward repeatedly despite the