

staff. If this is what they really mean their suggestions will prove difficult to implement for several reasons.

(a) Based on statistics available for our district this would cause a substantial (150–200%) increase in the number of patients needing consultant out-patient care and a corresponding (and very expensive) increase of consultant numbers (a figure some way ahead of that anticipated in *Achieving a Balance*). Without such consultant expansion, consultants will be permanently tied to out-patient clinics and the quality of other aspects of care given by consultants would be compromised.

(b) If all or most of this vulnerable group were under consultant care how will registrars gain necessary skills to manage this group confidently before they become senior registrars or consultants where greater clinical autonomy and less supervision may be expected?

(c) The main drawback with traditional out-patient care which we addressed in the paper is the often high default rate. There is no evidence to suggest that this should necessarily be lower in consultant-based care. Audit of this type of service should be a higher priority as the traditional model appears to be inefficient.

Our study demonstrates that there are few diagnostic (and therefore vulnerability) differences in attenders and defaulters. The priority development in this form of care should be to improve its efficiency by reducing the high default rates seen. It may be that this is due to the shortcomings of the actual method of care, rather than the grade of medical officer involved. Apart from audit of traditional models of out-patient care, we feel there should be more research on other methods of follow-up, e.g. transfer of out-patient clinics into general practice settings.

We would be grateful to hear from other colleagues who have studied this form of care or alternative methods of follow-up of chronically mentally ill patients.

AJIT SHAH

*Academic Department of Psychiatry  
The Royal Free Hospital  
Pond Street, Hampstead  
London NW3 2QG (correspondence)*

SEAN LYNCH

*St Charles Hospital  
Exmoor Street  
London W10 6DZ*

DEAR SIRs

In response to the letter from Drs Shah and Lynch, the key element in our original letter refers to the fact that registrars usually spend only six months in one post but they have omitted this phrase from the quotation they give.

The aim of our letter was to highlight the need to look at both service *and* training implications of current changes in service provision. We feel that this should be debated widely in the College and this view is supported by recent correspondence to the *Bulletin* (November 1990, 14, 681–682) as well as by Drs Shah and Lynch.

We do not believe that brief letters in the correspondence section can do more than highlight this problem. We are sure that this is a topical issue and that many options are being considered. We would be happy to describe our approach as part of widening such a discussion but we would not suggest that it is anything other than one possible way to tackle the problem.

I. A. DAVIDSON  
R. G. POOLE

*Royal Liverpool Hospital  
Central Liverpool Mental Health Team  
Liverpool L7 8XP*

### *Medical students' participation in psychiatric out-patients' clinics*

DEAR SIRs

Attendance at, and participation in, out-patients' clinics is an essential part of the training in psychiatry offered to medical students. It provides an opportunity for the students to assess relatively cooperative patients whose symptoms have not been modified by prior treatment. Unfortunately, there are problems surrounding this participation.

Many students find it distressing to be party to the mass interview of a patient and feel that some consultants are unsympathetic and inconsiderate in making patients endure these consultations.

Patients compelled to repeat their history before a 'crowd' of students have been known to change their stories, to the detriment of their assessment. An alcoholic man gave a perfect history of his condition to one student, but insisted (to the student's embarrassment) that she had misunderstood him when she presented his drinking history to the group.

Going through the initial clerkship by one student, and the subsequent presentation to the consultant and the group, can take up as much as three hours, further undermining the benefits of the consultation.

The needs of the patient and the students could be met equally if the new patient is clerked by a student for no more than one hour. The student and the patient then go in for a discussion for 15–20 minutes, with the consultant. The essential points are assessed and arrangements made for the care of the patient who, after no more than 1½ hours, goes home.

After the patient has left, the rest of the medical students join in and have a fuller presentation of the case, with discussion.

This way the students get their teaching (without ending up conscience-stricken about the consultation) and the patient gets the required attention, without spending all morning at it and without facing a dauntingly large, potentially embarrassing, group on his/her first attendance.

I. O. AZUONYE

*The Royal London Hospital  
(St Clement's)  
Bow Road, London E3 4LL*

### Psychiatry in literature

DEAR SIRS

Further to my comments (*Psychiatric Bulletin*, March 1990, 15, 167–168) on the article by Förstl *et al* (*Psychiatric Bulletin*, December 1990), 14, 705–707), I would like to draw your attention to the enclosed illustration from another book, *The Black Island* by Hergé.

It shows the intrepid reporter Tintin in action against the deviant psychiatrist, Dr Müller, a member of a gang of counterfeiters. To rid himself of Tintin, Müller has decided to commit him to a psychiatric hospital of which he happens to be the director. Yet another example of a writer anticipating future developments in (forensic) psychiatry, i.e. the confinement of healthy opponents in hospital, long before our profession showed interest in the problem!

KAREL DE PAUW

*Doncaster Royal Infirmary  
Armthorpe Road  
Doncaster DN2 5LT*



Tintin dispatches the evil psychiatrist Dr Müller in *The Black Island*.

Reproduced by permission of Sundancer.  
Copyright Hergé.

### Fregoli's syndrome

DEAR SIRS

I read with interest Förstl *et al*'s article dealing with psychiatric phenomena in relation to Tintin cartoons

(*Psychiatric Bulletin*, December 1990, 14, 705–707). During the many years that I have been reading Hergé's stories, I have become convinced that Mr Thomson, the gentleman who appears wearing a bowler hat is, *in reality*, a man with a moustache called Mr Thompson. Am I suffering from Fregoli's syndrome?

JOHN OWEN

*University of Bristol  
Department of Mental Health  
41 St Michael's Hill  
Bristol BS2 8DZ*

### ECT and magic numbers

DEAR SIRS

Despite sporadic yet vociferous opposition, ECT has long been seen as among the most efficacious of psychiatric treatments. If this tenet is true, and as we do not know why it is so effective, it would seem logical at least to delineate exactly what we do, so that those who succeed us may be as successfully ignorant as we are. We have commenced, therefore, by looking at what exactly constitutes a course of ECT treatment.

All courses of ECT given in two centres in Sheffield over the past four years were logged ( $n=405$ ). The final number each course finished on was analysed and revealed some interesting results. The mean number of treatments received was 7 (range 1–23). The figures were neither normally nor bi-modally distributed. Looking at the range of 4–12 treatments, 11 is the least favourite number to finish on, closely followed by 7 which therefore doubles up at being almost the "inverse mode" as well as the mean. You would have a 60% chance of finishing on an even number as opposed to an odd one which is of obvious statistical significance ( $P<0.001$ ). You would be even less likely to finish on one of the six prime numbers that fall between 1 and 13 ( $P<0.001$ ). The three most common lengths of treatment were, in order, 6, 12, 8.

So it seems we can confidently teach that for ECT to be successful it should not finish on an odd number, and certainly not on a prime number. In addition, there are other things to take into account, apart from patient response, when deciding the length of course of treatment, such as one's own superstitions perhaps!

SARAH ST-LEGER  
GWILYM HAYES

*Whiteley Wood Clinic  
Woofindin Road  
Sheffield S10 3TL*

### Psychiatry in Romania

DEAR SIRS

The Romanian Relief Appeal has been organising help and relief to orphanages and hospitals in and