Senior registrars in Yorkshire, when on duty, attend police stations at the request of police surgeons. This is not a contractual duty. The purpose of this arrangement is to assist the police surgeon in the assessment and disposal of detainees who may be psychiatrically disordered. Except for forensic trainees, senior registrars may know little about the law apart from the Mental Health Act. It is often the custody officer rather than the police surgeon (who will often no longer be present) who raises the question of 'fitness to be interviewed'. Custody officers not infrequently raise matters that are beyond the remit of psychiatric training: these include 'fitness to be interviewed', questions of reoffending and the likelihood of breaching police bail. It is in recognition of areas such as these which bridge medicine and the law that police surgeons are recruited and trained. 'Fitness to be interviewed' must remain the police surgeon's decision. Psychiatrists may inform and assist police surgeons, but should not substitute for them.

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Authors' reply: We are surprised by Dr Mitchison's views. Most assessments of 'fitness to be interviewed' are performed by police officers and police surgeons. Police surgeons, who may have minimal psychiatric training have the right to ask for specialist help after assessing a detainee who may be mentally disordered. Detainees should not be denied access to specialist services. We would suggest that discussion of the case between police surgeon and psychiatrist constitutes good practice. The issue of contractual duty is irrelevant to this complex and important subject.

Dr Mitchison suggests that psychiatrists should only offer advice but not make decisions on fitness to be interviewed. We believe that psychiatrists offering advice should take responsibility for their own assessments and recommendations, in the same way that they do elsewhere. This is particularly important as the issue will be open to debate later on in any future trial and the court will be interested to hear evidence at first hand.

It remains our opinion that psychiatrists should receive training on 'fitness to be interviewed'.

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Gastrointestinal side-effects

Sir: We report that nausea, vomiting and indigestion are more common in schizophrenic patients being treated with clozapine than those treated by the usual antipsychotic drugs. When the drug charts of the 31 in-patients suffering from schizophrenia at Llanarth Court Hospital were scrutinised on 15 January 1996 there were 11 patients on clozapine and 20 patients on the usual antipsychotics. Of the latter only one patient was on an antacid (Gaviscon) and none on ulcer healing drugs (ranitidine and omeprazole). However, six of the patients on clozapine (i.e. 55%) were on ulcer healing drugs and none on antacids.

On further scrutiny all four patients on clozapine for over one year were also on ranitidine. Two of the four patients who had been on clozapine for over 18 weeks and under one year were on ranitidine and omeprazole respectively. The three patients who had been started on clozapine recently (i.e. under 18 weeks), were not on ulcer healers. When the patients on ranitidine or omeprazole were asked why they had suffered from nausea, vomiting and indigestion all believed these symptoms were due to the clozapine as this was the only drug they were on. They also mentioned that on stopping the ulcer healers the symptoms recurred quickly.

Sandoz have had reports of cases of oesophagitis caused by clozapine as it influences the lower oesophageal sphincter pressure due to its anticholinergic properties. Can this be happening to a large number of patients on clozapine, but not being reported?

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Women in psychiatry

Sir: It is encouraging to read the Manpower Committee's recommendation that we need to "take every opportunity to make our speciality more attractive so that we can retain our current trainees and stimulate more undergraduates and newly qualified doctors into an interest in psychiatry" (*Psychiatric Bulletin*, March 1996, **20**, 177). These efforts should include making a career in psychiatry more attractive for women doctors, as over 50% of entrants to British medical schools are now female. Eighty per cent of these women are likely to marry and take on additional domestic responsibilities and the opportunity for part-time working must therefore be an important factor in encouraging women doctors to carry on working. Job-sharing is a relatively new solution to the problem but finding a local person at the same level and in the same speciality can be very difficult. The newly formed Special Interest Group for Women in Psychiatry is hoping to keep a job-share register which may make this task easier. There are no doubt other

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creative solutions for recruiting a higher proportion of both male and female graduates into psychiatry.

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Internet peer review

Sir: I was interested to read Dr Mortimer's letter in this month's *Psychiatric Bulletin*. She puts the case for Internet peer review very strongly. Internet peer review is a very successful idea and has been used in the International Journal of Psychiatry, *Psychiatry On-Line*. We have been publishing entirely Internet peer reviewed papers and articles since 1994. Your readers can find us on the following URL:
http://www.priory.co.uk/journals/psych.htm

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Disulfiram implantation

Sir: We describe the results of disulfiram implantation over a five year period within clinical practice at an alcohol service at a district general hospital.

The pharmacological basis of usage of disulfiram lies in its action on alcohol dehydrogenase preventing breakdown of acetaldehyde in the metabolism of ethanol. Early uncontrolled studies of disulfiram implantation showed significant improvement in abstention and social functioning (Malcolm & Maddens, 1973; Whyte & O'Brien, 1974). More recent placebo-controlled studies have consistently shown no differences between placebo and active treatment groups with regard to a wide set of alcohol-related variables (Borg *et al*, 1985; Johnson & Morland, 1991).

We reviewed the case notes of all patients (n=12) treated with disulfiram implants at Princess Alexandra Hospital between 1989 and 1994. All patients were seen by one psychiatrist (OJD), and implantation under one surgeon (MWM). Patients were encouraged to take oral disulfiram for 8 to 12 weeks prior to implantation. They were given an explanation of the mode of action of disulfiram before the medication was prescribed and gave informed consent. The 'challenge' approach was not used. Implantation took place under local anaesthetic, placing 6 tablets of disulfiram 100 mg into each iliac fossa using a trochar and cannula via a sub-umbilical incision.

Baseline data showed that the number of previous alcohol-related admissions ranged from 0–20 with median value 3.5. The patients with implants were at the more severe end of alcohol dependence considering the length of drinking prior to implantation (range 5–32 years, median 19), brief lengths of abstinence (range 0–24 months, median 6), amount (range 50–560, median 155 units/week) and frequency (range 3–7 days per week, median 7) of consumption.

Comparison, prior to and post-implant, showed reduced consumption and increased abstinence within the post-implant group. The liver indices also showed improvement. Analysis using Wilcoxon signed ranks tests showed significant decrease in units being drunk per week ($P<0.02$) and in number of days spent drinking per week ($P<0.03$). The outcome, to date, of this sample revealed six patients abstinent, four still drinking with little change in consumption, one had medical complications and one dead of an accidental overdose.

This sample has apparently benefited from disulfiram implantation, with half the patients having a good outcome. There were no skin complications noted. The criteria for selection for implantation were not constant, as seven patients requested implantation and it had been offered to the remainder when compliance with oral Antabuse was difficult. There is little doubt that implantation has a powerful placebo effect which is extinguished if patients are aware of a chance of receiving placebo (Johnson & Morland, 1991). The question remains whether it is ethically appropriate to use minimal amounts of disulfiram within an inert carrier to achieve similar results, if so then this should be offered to those requesting this treatment.

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Terminology

Sir: Can I invite you to withdraw your apology in relation to the word "dement". Although it is always more politically correct to preface a group of patients by the phrase "patients suffering from