would foresee little difficulty in fulfilling our criteria for approval.

In conclusion I welcome continuing constructive debate on these matters.

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Research in psychiatry

DEAR SIRS

Professor Crisp (*Psychiatric Bulletin*, March 1990, **14**, 163–168) is hopeful that his statement on 'The case for teaching and research experience and education within basic specialised training (registrar grade) in psychiatry' will be of interest. It may produce some controversy within the College. He makes a good case for research and teaching but I think it would be undesirable if all psychiatrists were expected to do research. In support of his case he notes that doctor means 'teacher'. By contrast, I would argue that research is not essential to the psychiatrist's job of treating psychological disorders.

I think the misunderstanding may have arisen because of the notion that research has advanced psychiatry. Is it true? Is psychiatry a science? What is a social science? These are questions that need research but are far too philosophical for most current psychiatric research.

Of course, research can be of value to psychiatry. Such education and training should be available in all training schemes. My case is that trainees should be allowed to choose whether they want to do research, and not be expected to do so as part of a career in psychiatry.

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Models of care for AIDS dementia

DEAR SIRS

Although it was flattering to see our Bow Group Memorandum being given such an extensive review by Professor Chris Thompson (*Psychiatric Bulletin*, February 1990, **14**, 126), I was somewhat disconcerted at the way his critique involved such a dismissive approach and rubbishing tone on my efforts to raise the public debate on an issue which seems to have obtained little currency or discussion elsewhere; namely the need to provide long-term institutional care for AIDS dementia patients at the end of this decade. I am quite robust enough to fully accept that some of my figures may be incorrect as they are based on averaging or interpolating some of the ranges of AIDS prevalence figures published in the Cox report, and furthermore my paper predates both the recent more optimistic predictions emanating from the Department of Health as well as the Dutch trial alluded to which suggests that Zidovudine will considerably alleviate the neuropsychiatric morbidity of AIDS, although this study makes no allowance for the possible emergence of Zidovudine-resistant HIV strains. As to the 4th International Conference on AIDS figures which were quoted, I drew upon two selected abstracts. The first is Abstract No 8565 done in Stockholm by Alexis, B. and Wetherberg, L. *et al* who examined 50 HIV infected patients with MRI and neuropsychological tests and found about 75% of the HIV infected homosexual men had frontal, parietal or occipital cortical atrophy with 70% having impairment of fine motor function with neuropsychological testing. The next Abstract is 8566 by Boccellani, A., Dilley, J. W. *et al* of San Francisco General Hospital on 46 hospitalised subjects with the first episode of *P. carinii* (i.e. the onset of AIDS). They found impairment in 78% on 6 of 10 neuropsychological tests. "These results support previous findings of a large incidence of cognitive pathology in patients with AIDS".

However I would like to take issue with a number of inaccuracies and points raised. I still maintain that AIDS patients if psychiatrically disturbed would be best kept in separate facilities even if physically ill, as in my experience general physicians are seldom happy to manage confused or disturbed patients as they find them too disruptive and are unfamiliar or unwilling to employ the Mental Health Act if this is required. The alternative, I suggest would not be an "ill-equipped mental hospital", as I clearly point out in our paper that any possible AIDS dementia unit would require very special joint care approaches between psychiatrists, infectious disease physicians, and genito-urinary physicians, and thus would require all the requisite funding and modifications to ensure adequate and modern medical care.

I also take particular issue with the very insensitive and critical attitude of Professor Thompson to our long-stay hospitals. I have spent a considerable amount of time as a junior psychiatrist at a long-stay mental asylum and was not aware of working in "an unmanageable sprawling complex in which individuality of all but the most disturbed was submerged among the faceless masses of the mentally ill". Frankly, this frontal attack on our long-stay hospitals does a disservice to their dedicated staff and patients whose morale is already at a nadir faced with the prospects of imminent closure and an uncertain future with social services managed community care.

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