adversarial situation. However, £12,000,000 is a lot of money; are we spending it wisely and appropriately? Should we detain people when there are insufficient facilities for what is considered adequate treatment (Eastman, 1994)? It may be argued that *all* compulsorily admitted patients should have a tribunal or a managers' appeal. This would very greatly increase numbers and costs. Further, if all patients incapable of giving consent (e.g. those with confusion) were compulsorily admitted there would be a vast increase in demand for tribunals and appeals. Under these circumstances a form of rationing would have to be introduced as, quite apart from costs, the service just could not cope with the work such numbers would produce.

Has there been a similar study to look at the cost of managers' appeals? Further studies on tribunals and appeals should determine why appeals are made; it may be on the advice of a fellow patient or of an enthusiastic member of staff, who has the individual patient's right (or other matters) at heart, not the overall costs and running of the service.

The Mental Health Act Commission, on its annual visit, collects figures for population served, admissions, sections, tribunals and appeals, cancellations and outcomes. (The word 'success' is not to be used concerning tribunals or appeals; success is that a fair and proper hearing was given, not that a particular decision was made). The processing and publication of such data would help individual units or regions to consider their rates.

Perhaps the day will come when there are 'preliminary screeners' for tribunals and appeals. Such a person would look at *every* case and could then choose as many cases as could be 'afforded' which would then be passed on to subsequent, more detailed, hearings.

EASTMAN, N. (1994) Mental health law; civil liberties and the principle of reciprocity. *British Medical Journal*, **308**, 43–45.

M.T. MALCOLM, *Clatterbridge Hospital, Bebington, Wirral L63 4JY*

Sir: I was delighted to see the recent article by Blumenthal & Wessely (*Psychiatric Bulletin*, May 1994, **18**, 274–276) pointing out the cost of Mental Health Review Tribunals and calculating that the total cost of these tribunals are £12,274,380 per annum.

It has long been my contention that these tribunals are of no real benefit to patient care and waste a great deal of the time of doctors and social workers. I have noted the bizarre situation whereby psychotic patients of mine are asked shortly after admission on section 2 and section 3 of the MHA if they would like to appeal against their section. Being psychotic they have no insight into their mental illness and so take up the offer of appeal against section. They are assisted in so doing by the Legal Advice Project at the hospital.

At the tribunal itself the lawyers use an adversarial principal which makes me appear to be an unreasonable person who is seen to be locking away patients and depriving them of their civil liberty. This is far from the case, as like most psychiatrists, I compulsorily admit patients only when necessary, and always in their best interest.

Money is being poured into Mental Health Tribunals which could be used to fund better community care. The 1959 Mental Health Act provided a perfectly good system of appeal using Mental Health Review Tribunals, but it was less frequent and did not involve the additional burden of managers' hearings.

The 1983 Mental Health Act uses a legalistic and expensive system which is of no benefit to patients and the College should take urgent steps to reform it.

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General practice training for psychiatrists

Sir: I was interested to read Burns *et al*'s paper on general practice training for psychiatrists (*Psychiatric Bulletin*, May 1994, **18**, 286–288), having been one of the 18 trainees who took part in the placements, and thought a 'user's perspective' might be worth recording. I was probably unusual in actually volunteering for the post as it certainly was one of the 'hard to fill' spots on the rotation at the time. My reasons for volunteering were two-fold. One was a glimmer of interest in general practice as a career, the second was that I had been involved in regular liaison meetings with the practice to which I would be attached in my preceding psychiatric registrar post.

I valued the six month placement enormously. The partners were all extremely accommodating to my psychiatric training needs, even allowing me to attend additional family therapy commitments. I found my opinions on psychiatric issues being valued, while it was still expected that I would be a 'normal' GP trainee and not the resident psychiatrist. My general medical skills improved, my awareness of minor psychiatric morbidity increased and the pressures this created for GPs understood far better. It was actually quite difficult at times to decide who should be referred on to mental health professionals and I became slightly more sympathetic

to the 'inappropriate GP referral' we so often complain about.

My trainer was an older GP, who had worked in the practice for many years. His knowledge of, and relationships with, many families under his care was impressive and I realised how often we miss out on tapping in to such a resource by poor liaison with the family doctor.

The post was not always enjoyable; I found the endless 'coughs and colds' monotonous, the winter 'flu epidemic of 1990 (which increased home visits threefold) stressful, and was irritated by spending seemingly endless hours on the telephone trying to arrange an acute medical or surgical admission. At the end of my time, I finally decided on psychiatry as the career I would definitely pursue. However, overall I gained so much and hope there will continue to be similar opportunities available for other interested psychiatric trainees in the future.

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GPs' attitudes towards sectorisation

Sir: I was disappointed to read Dr Chaudhary's account of the unsuccessful attempts of his community care NHS trust to sectorise their service (*Psychiatric Bulletin*, May 1994, **18,** 308).

We are all becoming aware of the importance of involving GPs in decisions about the way the services are delivered and the need for increased communication. While in the past there has been an acknowledgement of this issue, it has assumed greater importance with the changes in funding arrangements. In my own experience the attitude of GPs towards proposals for sectorisation is often negative, but in practice their concerns tend not to be borne out. For the GP there is the loss of the ability to make referrals not only to different consultants but also to choose different mental health professionals. This can lead to unnecessary duplication while the sectorised team forms a filter mechanism for allocation to the most appropriate discipline. Given the up to 20-fold variation in referral levels between GPs and the varying ability and interest in psychiatry, the failure to sectorise tends to compound the existing inefficiencies in the way our services are provided. The task seems to be to convince GPs that the potential disadvantages from their perspective are far outweighed by the gains to the overall service provided for their patients.

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Surviving as an overseas doctor

Sir: I was interested to read Swaran Singh's advice for overseas doctors (*Psychiatric Bulletin*, May 1994, **18,** 302–303), in which he sets out what to do and not to do when working in a strange and new culture. In a second paper (Singh, 1994) he describes in more harrowing terms some of the difficulties he has faced as a foreign doctor in England. For the past 18 months I have been working in Hong Kong, and as a foreign, overseas doctor in this very different setting, I can identify with many of his problems, from getting used to the food, to adjusting to the way different professionals work together.

The most obvious difficulty faced by a foreign doctor is that of language. In my case, I am still not able to speak the same language as most of my patients and rely on medical students, junior doctors or nurses for translation. I have found it surprisingly easy to use untrained interpreters in assessing a patient's mental state, but there are occasions in which my inability to speak the same language as a patient has been frustrating.

The authority of doctors was also something that was new to me. As a white doctor, a 'foreign devil', I am regarded by some patients as even more of an authority figure than a Chinese doctor. This hierarchy extends to team members, thus interactions between disciplines are more formal than in England and decisions are almost always made by the medical staff.

Overseas doctors, wherever they go or wherever they are from, can expect to have to spend several months adjusting. There are language problems, cultural problems and a new way of working to learn. The patients themselves are remarkably similar, given the completely different backgrounds, culture, and language that they have. I have found this experience rewarding and feel that it has broadened my outlook both within psychiatry and without.

SINGH, S.P. (1994) Cultural adjustment and the overseas trainee. *British Medical Journal*, **308,** 1169.

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Fragmentation of community services

Sir: Drs Fear and Cattell (*Psychiatric Bulletin*, May 1994, **18,** 263–265) comment on the fragmentation of essential community services with the advent of multiple purchasers who can dictate where their patients receive care.

I would urge the NHS to look carefully at these developments, as not only will you see fragmentation, but ultimately fewer services may be available. In many parts of Canada there are no defined catchment areas for general hospitals and no co-ordination of services. Many towns have at least two hospitals (originally Protestant and Catholic). Our own city has three general