other professionals' roles, especially those of psychologist, social worker, and educationalist. Can we really cordon ourselves off from these? Does not the practice of psychiatry extend to some, or all, of these at one time or another?

While I cannot see an end to the discussion, and am conscious of adding fuel with this letter, the following issues need to be addressed and dealt with unequivocally as far as the consultant's responsibility within the NHS is concerned.

(a) *The ultimate responsibility:* Here the consultant has professional, ethical and legal responsibility which cannot be devolved. Other disciplines within the NHS are not so clearly legally defined.

(b) *Responsibility with authority:* While most people acknowledge the responsibilities vested in consultants, consultants are rarely given the authority to pursue their responsibility.

(c) *Consultants and multidisciplinary teams:* Once again the roles of each must be clearly defined. It must be recognised "that the legal, professional, ethical, diagnostic and prescriptive responsibilities of the medical profession cannot be delegated to a multidisciplinary group when treating an individual patient." (Royal College of Psychiatrists, 1977).

(d) *Workload of consultants:* Whether we should confine our work to the psychiatry of mental handicap or extend it needs to be decided. My own view is that we should extend our role and emulate those in the academic departments of mental handicap who do not confine themselves to psychiatry and take on a much wider role of dealing with neuro-psychiatry and other areas of mental handicap, including paediatric and geriatric care. Obviously there has to be a change in emphasis in the training of future consultants with this in mind. I would also suggest that we are called consultants in mental handicap and not by other names currently used.

(e) *Role as an expert, leader, co-ordinator, arbiter, adviser and provider of services:* A consultant is the first to recognise that he cannot undertake all these roles at the same time and he has to be accommodating and helpful to members of other disciplines; the others must accept and respect his role and responsibility. We all have roles to play; let us define them and not work at variance.

(f) *Consultant and managers:* With the new managers, whose jobs depend upon achieving specific targets by certain dates, there is an 'unease' about each other's role. Most managers see consultants as standing in their path and a confrontational attitude results. It is the duty of management at all levels i.e. Region, District and Unit, to see that a consultant's 'somewhat different' if not special role and responsibility is upheld.

It was interesting to note from *Hansard* (27 April 1989) that when the closure of mental hospitals was debated, Lord Henley, on behalf of the Government, stated "the question of discharge of a patient into the community is entirely a matter for the consultant psychiatrist who must be happy that the patient will benefit from a more independent living environment." It is time that the DHSS gave an undertaking on the role and responsibility of a consultant in mental handicap in the NHS with the clarity of the foregoing statement.

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Reference

ROYAL COLLEGE OF PSYCHIATRISTS (1977) The responsibilities of consultants in psychiatry within the National Health Service. *Bulletin of the Royal College of Psychiatrists*, September, 4–7.

Day care of the elderly mentally ill by voluntary workers

DEAR SIRS

In 1986 our 50 place day hospital for the treatment of elderly mentally ill patients was under pressure because of the lack of therapeutic day facilities in the community for recovering or recurrent mentally ill elderly people. The local council offered day care mainly for those patients suffering from dementia, but it was without social stimulation and was unacceptable to most of the functionally mentally ill. Age Concern was well established in Tameside, providing day centres for the physically disabled.

Health Service funding, initially for three years, was provided to enable Age Concern to open two day centres in ordinary community buildings to provide social stimulation and rehabilitative activities to patients referred from the day hospital. These buildings are not suitable for the day care of severely demented patients. The main staff are trained volunteers with one and a half community programme trainees and a project co-ordinator. There is also a joint management panel and ongoing support from a consultant, community nurse, health administrator, social worker and local Age Concern director and adviser. The first centre opened in November 1986 and four days a week are now available with a weekly attendance of 60 members. Initially, training courses have been provided by Health and Age Concern staff for volunteers. Close liaison has developed with the

https://doi.org/10.1192/pb.13.12.706 Published online by Cambridge University Press

day hospital. There is regular feedback to all consultants on the progress of attenders. The atmosphere at the centres is non-medical with an emphasis on encouraging social interaction, self-confidence and increased independence. The life experiences and interests of volunteers and members can be drawn on. Volunteers visit the attenders at home when necessary.

A comparative costing per attender per day (including transport and meals, but excluding medical, community psychiatric nurse and social work costs) is:

Day hospital £28, Age Concern day centre £9.

Diagnostic groups are: psychoses (45%); neuroses (40%); mild dementia (15%); living alone (50%); and aged over 75 (45%).

The advantages of the day centres are:

(a) relieves the day hospital at low cost to the health service
(b) non-hospital atmosphere reduces sickness behaviour
(c) personal attention of a high ratio of enthusiastic volunteers and members' choice of activity, e.g. craft, games, conversation, cookery, trips
(d) access when necessary to consultant, community psychiatric nurse, social worker, etc.
(e) community psychiatric nurse supports meetings to share information of members and volunteers about social facilities in the general community, resulting in 30% of patients moving on
(f) volunteers receive training – some of them have moved on to paid work with the elderly.

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Criteria for consultant posts

DEAR SIRS

The letter from Dr Lovett in your August issue struck a sympathetic chord in my mind as my late predecessor as Medical Administrator frequently accused the College of "moving the goalposts" in connection with the Approval Scheme.

Of course the College is quite properly concerned with defending and improving the practice of psychiatry and will thus inevitably be continually raising the criteria for training and for appointing to consultant posts. This can, however, cause some difficulty at a practical level if the guidelines are interpreted rigidly. Particularly in the less popular specialities of Psychiatry of Old Age and Mental Handicap, a situation may arise where the only candidate for a post fails to a greater or lesser degree to meet the College's criteria for appointment.

It seems to me that it may on such an occasion nonetheless be right to appoint such a candidate when not to do so will lead to no service being provided for that particular group of patients.

I would make a plea that the College should allow its advisers on Appointment Committees to exercise a reasonable amount of flexibility in these circumstances.

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Overseas doctors' training scheme

DEAR SIRS

I very much welcome the Overseas Doctors' Training Scheme proposed in 'The Work of the Overseas Desk' (*Psychiatric Bulletin*, May 1989, **13**, 260–262). I have some reservations I would like to express about it.

Implementation of the scheme is subject to the following guidelines:

(a) no advertising for the SHO/Registrar post is necessary
(b) Advisory Appointments Committees are not necessary
(c) Health Authorities are able to agree contracts in advance of appointments.

The machinery for implementing the scheme involves:

(a) an overseas sponsor
(b) the Royal College of Psychiatrists which will identify training posts in the NHS for the candidate and make arrangements with the GMC for limited registration.

Professor Sims mentions that, "The whole scheme depends totally on the vindication of mutual trust between the candidate, the overseas sponsor, the College and the receiving training scheme organiser." I would like to be constructively cautious at that point for the sake of choosing the trainee who will benefit most from the scheme as well as for the sake of the post the trainee is going to fill, and would therefore raise two queries:

(a) Are overseas candidates getting equal chances?
(b) Are we in a position to select the best candidates?

In my view there are three possible approaches to selecting candidates:

(a) to arrange for the Appointing Committee to hold interviews once or twice a year in the overseas country in order to give equal opportunities for job competition among junior doctors and to reassure a good choice of an overseas doctor in the UK. Successful candidates should then be subject to a working contract with the Health Authority. This

https://doi.org/10.1192/pb.13.12.706 Published online by Cambridge University Press