DRCOG etc). It is for the Examination Committee to decide how changes should be implemented.

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DEAR SIRS

Being an overseas trainee working on the overseas doctors training scheme, I fully support the points made by Dr Mathew (*Psychiatric Bulletin*, 1991, **15**, 699–700). I feel that he has raised an important issue. It would indeed be impossible for all those overseas trainees who wish to take membership examination to make the full number of attempts for their Part I and Part II of the MRCPsych.

Being allowed to stay in the UK for only four years will certainly cause a lot of anxiety among those candidates who fail to pass within the first few attempts. The Dean and the Chief Examiner in their reply have pointed out that most of the overseas trainees do not want to take the MRCPsych examination which I think is not true. Given the chance to take the examination, most of the doctors will wish to get a high class British qualification. The suggestion of an alternative examination is very good and the College should consider it seriously.

The Dean and the Chief Examiner have also mentioned that it would involve a lot of expenditure to conduct such an examination. As far as the financial aspect is concerned, I think that the College can recover a handsome amount of money from the candidates in respect of fees. Introduction of the DPM or any equivalent qualification would especially be of benefit to those who are limited to a few years in the United Kingdom or who are unable to pass the MRCPsych examination.

The College may not agree with the idea of unlimited attempts for DPM but this examination can be organised according to the standards set by the College.

MRCPsych is undoubtedly the most prestigious qualification and even if the DPM examination is started its value would not diminish, so at least some consideration should be given to this idea.

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DEAR SIRS

Thank you for giving us the opportunity of reading Dr Zafar's letter.

I think that reference to our reply will indicate that we said *many* overseas trainees, not *most* will not wish to take MRCPsych seriously. The question of an alternative examination is being considered by the College as we indicated.

With regard to the financial aspects, as Dr Zafar points out, it might well be possible to make a new examination self-financing, but money is not the only matter to be considered. The setting up of any new examination takes other resources, particularly space and personnel, and this has to be considered with respect to the College generally.

Dr SHEILA A. MANN
Chief Examiner
Dr FIONA CALDICOTT
Dean

Requirements for submission of medical articles

DEAR SIRS

The recent correspondence about requirements for submission of medical articles (*Psychiatric Bulletin*, 1991, **15**, 703) highlights the need for a review of the current system and a widening of the current debate. The prevalence of disputes among authors is unknown. Up to now authors have operated an honour system and are assumed to have discussed alterations and the order of authors. Problems can occur with junior doctors who are under increasing pressure to publish in order to further their careers. It may not always be clear to them what standards apply. Some journals require written permission from all authors before they will publish. Perhaps journals should have a set of guidelines which are sent to the authors on acceptance of an article. These could include confirmation that the order of authorship has been agreed and reflects an appropriate input into the article and that all authors have seen the final draft of the article. The originality and authenticity of the research should also be confirmed. A consensus in guidelines among editors of journals would also help limit confusion.

Research determines a major part of a junior doctor's career progression. This results in pressure to publish which can lead to inadequate and poorly supervised research. The proliferation of medical journals is testament to this. Perhaps appointments committees could also limit the number of papers a candidate could cite.

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Editorial note. Our Notice to Contributors now states that all material submitted for publication to the *Psychiatric Bulletin* should be accompanied by a covering letter to the editors signed by all authors.

When relatives refuse to give consent

DEAR SIRS

With regard to the letter concerning the use of the Mental Health Act 1983 from Jon Kennedy (*Psychiatric Bulletin*, 1991, **15**, 701), I would like to comment

that while I agree that Section 3 of the Mental Health Act contains important safeguards for patients providing consultation with the nearest relative, I would like to add that this in some cases is merely a complicating factor. I have been involved in the detention of patients on a Section 3, where the next of kin has absolutely refused to give consent for such an order. This has resulted in patients being inadequately treated and leaves the psychiatrist in a state of helplessness. On the whole, Social Services appear to be loathe to displace relatives as next of kin and in view of the long and complicated processes of same, this is hardly surprising. However, as this is the only way around the problem I feel that some patients are being treated less than adequately when the relatives refuse to give consent. Furthermore, I have found when the next logical step, i.e. displacement of the nearest relative as next of kin, is pointed out to the nearest relative that they tend to withdraw their objections which can be seen as a subtle means of manipulation which is hardly in the spirit of the act.

Dr Kennedy suggests that, when a patient is well known to the service, community care should be offered without recourse to hospital admission. I find this rather naive and in the present climate of bed shortages, etc. I find it hard to believe that there are many psychiatrists admitting patients unnecessarily under the Mental Health Act. However should there be a clause in the current Mental Health Act to include compulsory treatment in the community, then perhaps his suggestions would be more relevant.

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Need for continuing support for carers

DEAR SIRS

I would like to comment on the letter from Drs Lawrence, Blakely and Rossor headed 'Every Day Life in a Drug Trial' (*Psychiatric Bulletin*, **15**, 770). The substance of the letter concerns a phenomenon which providers of services for dementia sufferers view with a mixture of pleasure and pain. It is a privilege for the research team members to enter, however briefly, into the real life stories of those caring for the demented. It is no less a privilege for the client group to have the attention of talented workers in the research field. The danger lies in the tendency for the researchers to become briefly over-involved and to devalue the work of those permanently "out there" struggling with inadequate resources to prop up an admittedly inadequate system. That the involvement in the drug trial has been "interesting and formative" in the researchers' training experience is not in dispute. The advantage which their involvement confers on the "clients" would be lasting if they were to ensure that there would be some continuing support for the carers after the project team's withdrawal. In many cases the research subjects will be known to local statutory or voluntary agencies. Where they are not, the team members should be asking questions.

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Psychological treatments by psychiatrists

DEAR SIRS

I was interested to read the letter from the Dean regarding her conversations with the President and her concerns about improving the capacity of psychiatrists to engage in psychological treatments (*Psychiatric Bulletin* 1991, **15**, 699). I was particularly interested because I had just read in *Psychiatric News* of 15 November 1991, a publication of the American Psychiatric Association, an account of an address by the President of the Association, Dr Lawrence Hartmann, at the opening of the Institute on Hospital and Community Psychiatry. In this he said, "I worry that in 1991 psychiatry has regressed from what was a fairly sound bio/psycho/social model, partly because of biological advances." "As part of the new biological advances and the remedicalization of the field, psychiatry as a model of illness and wellness has shrunk back from bio/psycho/social integration towards the narrower, more purely physiological medical model . . ."

Humane values and bio/psycho/social integration "require us to be aware of and care for and treat WHOLE people – whole biological, psychological, and social people, in context and over time." He quoted George Engel, M.D., who questioned in his writings the exclusively biological focus of modern medicine. That focus "assumes disease can be fully accounted for by deviations from the norm in measurable biological variables . . . It leaves no room in the framework for the social, psychological, and behavioural dimensions of illness".

Dr Hartmann continued, "In some ways, we psychiatrists with our excellent but unbalancing advances in brain biology – probably need to pay attention to Engel's work even more than we did fifteen years ago."

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A psychiatrist with beds . . .

DEAR SIRS

How refreshing it is to read Professor Cox's article (*Psychiatric Bulletin*, 1991, **15**, 684–686) expounding