hospitals, each with general psychiatric units, and one psychiatric hospital within the city limits. Only one of those general hospitals has any formal limited psychogeriatric funding. Particularly in the case of those patients who are 'not wanted by other services', frequently their needs are not met at all. Our own District Health Council, under pressure from the Ontario Ministry of Health, is now at long last looking at the need to develop co-ordinated services in geriatric psychiatry as the only way to ensure adequate access based on the needs of the community.

In the ideal psychogeriatric model, most new patients would be seen in domiciliary consultation (DC). In the ideal model more than one discipline may need to be involved at a DC level, especially when the patient is not going to be admitted to hospital. Where the psychogeriatrician and nurse or social worker work closely together, the patient can only benefit. Some, but not all patients, may benefit from assessment by one discipline alone.

DAVID J. HARRIS, *University of Western Ontario, Victoria Hospital, London, Ontario, Canada N6A 4G5*

The reorganised mental health service

Sir: Although now retired, I very much enjoy the articles in the *Bulletin*, with their emphasis on the practical problems facing those working in the now reorganised mental health service. In your April 1994 issue, you have two articles on how the operation of the internal market is likely to effect the functioning of such a service.

I was, however, taken aback by one paragraph in Gregory Richardson's article 'Psychiatry: a contracting specialty' (*Psychiatric Bulletin*, April 1994, **18**, 200–202). Under 'Action required' he mentions the need:

> "to clarify and separate the many different aspects of the psychiatrists' work-loads so that costs can be allocated appropriately; for example, by clarifying the percentage of time spent in general psychiatry and how much with each special interest, and then further by breakdown into time spent on in-patient and out-patient work, then dividing that by the in-patients and out-patients, in order to calculate costs per case. Follow-up appointments, letter writing, attendance at case conferences etc must all be included to ensure costs are accurately calculated . . . Travelling time and consultation work may have to be priced separately and added to out-patient costs of individual patients".

After this breathtaking foray into health economics, can I suggest to Dr Richardson that he also includes time spent on thinking and worrying about some patients in his costing exercise. And what about charging a little more for those we treat with some empathy and even more when combined with warmth and genuineness.

I want to be fair to Dr Richardson. The internal market has created serious problems for the financing of a good psychiatric service and his article is meant as a constructive contribution to solving the complex difficulties involved. It is his acceptance of the principles of the internal market which has resulted in the nonsense he has written in the paragraph quoted.

BENJAMIN STEINBERG, *Emeritus Consultant Psychiatrist, Southampton and SW Hants District Health Authority*

Sir: Dr Steinberg has had the good fortune to retire from the rigours of the market economy in the National Health Service. We not face an era in which consultants' time and money must be clearly accounted for or it will not be paid for by purchasers. We can only do this if we clarify what our work involves in its many aspects which include follow-up appointments, letter writing, attendance at case conferences, consultation work and travelling time. For as the contracting system becomes steadily more sophisticated we will have to account for our expenses on each individual case; after all when we go to Marks & Spencers we buy things individually, not by department.

Consultants receive a reasonable salary which I am sure is a baseline to acknowledge that dealing with patients with empathy, warmth and genuineness is a basic requirement for the job.

I don't have to like this system, but I have to work in it if I'm going to get the best for my patients.

G.J.R. RICHARDSON, *Lime Trees Child, Adolescent and Family Unit, 31 Shipton Road, York YO3 6RE*

Psychiatric training and the European Union

Sir: Although Jan Neeleman & Jim van Os (*Psychiatric Bulletin*, April 1994, **18**, 193–195) provide an interesting comparative study of psychiatric training in Europe, their conclusions do not accord with the facts.

Their general thesis is that the changes to training required under European Union Medical Directives will mean the end of training and psychiatry as we know it in the UK. Existing subspecialities will disappear and psychiatric research will suffer.

Meeting the EU directives simply means that any specialist within the EU has the right to practise his or her speciality in Britain.

Currently, this may appear to disadvantage UK doctors, who have to undergo longer training than their European counterparts. The Calman Report addressed this issue by proposing improvements to training that will mean that it is shorter and more structured, while not affecting quality standards (Kisely, 1993).

Content of training will remain the prerogative of the competent body in every member state. In the UK this will be the Royal College of Psychiatrists. There is no question of UK trainees having to learn about neurology or *la bouffee delirante*, unless they wish to.

In addition, there is no reason why the introduction of a unified training grade and shorter training would mean the end of psychiatric subspecialties. In Australia and New Zealand, where training in a unified grade lasts only five years, their college has sections for child psychiatry, alcohol and other drugs, forensic psychiatry, psychiatry of old age, psychotherapy, and social & cultural psychiatry. If anything, training in Australia is more comprehensive, in that exposure to child and liaison psychiatry is obligatory.

I happen to enjoy research, having just completed one academic job, and starting another later this year, but many trainees wish to concentrate on clinical, teaching or administrative duties. There has been an over-emphasis on the requirement for research in medicine in this country. Experience in research should be available for everyone who is interested, not as a means of filling in time while awaiting a consultant post.

There are very real dangers to training and the speciality with the advent of the changes envisaged by the Calman Report, but not the loss of subspecialities or research opportunities. If the government persists in implementing change without additional funds for greater numbers of consultants, career opportunities may well worsen. Loss of training opportunities, or pay, are far more likely to arise out of the government's reforms of the health service. Additionally, training and pay may be influenced by the opportunities for Trusts to employ doctors without regard to national terms and conditions of service or manpower restrictions.

KISELY, S.R. (1993) The future of psychiatric training after the Calman Report. *Psychiatric Bulletin*, **17**, 610–612.

STEVE KISELY, *Northamptonshire Health Authority, Highfield Road, Cliftonville Road, Northampton NN1 5DN*

We cannot look into the future. That is the main reason why we have spoken of *likely* consequences of Euro-harmonisation for psychiatric training (*Psychiatric Bulletin*, April 1994, **18**, 193–195). It is unclear to us how it is possible for Dr Kisely to state that our conclusions do not accord with the facts. Which facts? The process of harmonisation is only in its earliest stages and, as far as we are aware, Calman's recommendations have not been implemented yet in psychiatric training. We suspect that Dr Kisely is creating his own argument, disregarding one of the very few hard facts in this discussion; according to the Calman Report (p. 33), training will have to be shortened by one to three years to a maximum of five to six years. A simple calculation teaches us that, if the duration of subspecialty training were to remain at its present duration (four years), one to two years will be left for general psychiatric training. As this is unlikely to be acceptable we expect that the only option will be to shorten subspecialty training. A similar arithmetic is applicable, *mutatis mutandis*, to time spent in research. *Quod erat demonstradum*!

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Ethical dilemmas in drug treatments

Sir: While the case described by Tyrer and commented upon by Smith & Adshead (*Psychiatric Bulletin*, April 1994, **18**, 203–204) would appear to represent a commendably flexible interpretation of the doctor/patient contract, I fear that due to other factors, such an approach is increasingly likely to be impractical and for the responsible medical officer, dangerous.

Coid (1994) has summarised the increasingly alarming position in which psychiatrists are being placed in terms of their accountability for the acts of their patients and it seems quite clear that if Tyrer's patient were to behave violently and cause harm to someone, then Tyrer would be held accountable for this and possibly face disciplinary proceedings.

The dilemma, I would suggest, is not so much between professional standards and patients' freedom but now between professional survival and that freedom.

COID, J. (1994) Failure in community care: psychiatry's dilemma. *British Medical Journal*, **308**, 805–806.

D.R. DAVIES, *Tone Vale Hospital, Norton Fitzwarren, Taunton, Somerset TA4 1DB*

Sir: We are grateful to Dr Davies for his comments on our paper. While his views may appear somewhat alarmist, we would agree that in the present political climate doctors are vulnerable to being scapegoated when their patients behave dangerously. The newly introduced Supervision Register is a prime example of this. To what extent psychiatrists can be held liable for their patients' behaviour is unclear. We believe that