psychiatrists understand and use the notion of "cannabis psychosis" – was not my own idea: that I made clear in title and text, and indeed was one of the reasons for preparing the work for publication. Psychiatrists, as I noted, must now be prepared to carry out research projects suggested by the minority groups whom for so long they have treated as the objects of "disinterested" academic research.

In the study in question I carried out the work in my own way, and the groups concerned were not collaborators in the method nor in implementation. That might perhaps be our next step; indeed even offering our professional research procedures to psychiatric service users and their communities to use as they see fit. That was not intended in this study, nor have I claimed it to be so.

I am *accountable* to the groups who advised me; they are not however *responsible* for the way I carried out and used their suggestions. Given the power of psychiatry I certainly think we should be wary of claims that we carry out research *on behalf of* others, but we can hardly hold others accountable for our actions.

That issues of quite serious responsibility are involved is perhaps indicated by reviewing the history of "cannabis psychosis" in Birmingham. In the 1970s it was not apparently diagnosed among either blacks or whites (Royer, 1977).

By the mid-1980s it was diagnosed 95 times more commonly in local Afro-Carribbean patients than in whites, and was an issue given extensive coverage (McGovern & Cope, 1987). The heavily publicised research project was then started. By 1988 the diagnosis had disappeared completely (Milner & Hayes, 1988a, b).

Whether this is something one "takes the credit" for (Dr Cook's phrase) depends on the future standing of cannabis psychosis: if it becomes a recognised category then clearly the paper will hardly be regarded with enthusiasm. Blame or credit, I remain accountable. (Alternatively one might argue that it was irrelevant, that it was merely part of a general lay and professional unease with the diagnosis.)

ROLAND LITTLEWOOD

University College and
Middlesex School of Medicine
London W1

References

MCGOVERN, D. & COPE, R. (1987) First admission rates for first and second generation Afro-Caribbeans. *Social Psychiatry*, **22**, 139–149.

MILNER, G. & HAYES, G. (1988a) Correspondence. *British Medical Journal*, **296**, 1333.

—— & —— (1988b) Correspondence. *British Medical Journal*, **297**, 359.

ROYER, J. (1977) *Black Britain's Dilemma*. Roseau, Dominica: Tropical Printers.

Let the old man drink

DEAR SIRS

The physiological changes of ageing make the elderly more vulnerable to alcohol (Vestal *et al*, 1977). Organic brain affliction, and cardiac and pulmonary diseases increase this sensitivity further. Alcohol in them, even in small doses, can cause acute confusion, disinhibited aggressive behaviour, sleep disturbance and emotional lability (Schuckit, 1982). Despite the Royal College of Physicians' advice on the safe drinking limit, such limits in the elderly are still unknown.

Failure of doctors to recognise the social decline and relying on abnormal physical signs for diagnosis creates difficulty in detecting the problem drinker (Murray, 1986). But surprisingly we find some psychiatrists, despite evidence of alcohol's contribution to the ill health in their elderly patients, are reluctant to wean them off. On the contrary, they "prescribe" "whisky" or "brandy" to some as a daily dose or as a night sedation. The rationale of this approach is (a) it is too late to treat; (b) he has lived so long, leave him alone; (c) it is a pity to take away his favourite drink. We agree with the elderly people's right to enjoy a drink, but believe that the sick elderly should be advised to stop drinking.

Although *Proverbs* (31:6,7) quotes, "Give strong drink unto him that is ready to perish, and wine unto those that be of heavy hearts. Let him drink, and forget his poverty, and remember his misery no more", this pessimistic and do-nothing view is at variance with our understanding in the field of geriatrics. The future welfare of sick aged people depends on more optimistic endeavours.

We look forward to readers' comments on this matter.

M. AL-BACHARI
P. ACHARYYA

Leighton Hospital, Crewe

References

MURRAY, R. (1986) Alcoholism (Ch. 10. *Essentials of Postgraduate Psychiatry*, eds P. Hill, R. Murray & A. Thorley). New York: Grune & Stratton. 311–338.

SCHUCKIT, M. A. (1982) A clinical review of alcohol, alcoholism, and the elderly patient. *Journal of Clinical Psychiatry*, **43**, 396–399.

VESTAL, R. E. *et al.* (1977) Aging and Ethanol metabolism in man. *Clinical Pharmacology and Therapeutics*, **21**, 343–354.

Grading of nurses

DEAR SIRS

I have just discovered that the staff nurses, who work with me in our psychiatric day hospital, have been

given a Grade D in the re-grading which compares unfavourably with their colleagues working on the in-patient unit. In common with many day hospitals, our nurses exhibit a high degree of clinical autonomy and are responsible for a substantial caseload of community based patients. They must liaise with families, community carers and the psychiatric firms to which the patients are attached. In addition they are responsible, with other members of the multidisciplinary team, for developing care plans for their patients, and ensuring that these plans are executed, and take a large part in maintaining the therapeutic programme of the day hospital. Since the majority of our patients have long-term disabilities our staff nurses often have to maintain contact with patients over many years.

This work contrasts sharply with the tasks of a staff nurse on an in-patient unit, arguably requiring a much higher degree of professionalism than is generally found among nurses who have not yet left the security of the hospital in-patient base.

I would be interested to know from colleagues whether they too have discovered anomalies in the grading of the nurses with whom they work and what, if anything, they have been able to do to remedy the situation. There is no doubt that if, in my unit, the grading is unchanged we shall be unable to retain and recruit staff. This will of course suit management, desperate to save money, but is hardly designed to encourage policies of community care.

FRANK HOLLOWAY

St Giles' Hospital
St Giles' Road
London SE5

Mental Health Review Tribunals

DEAR SIRS

Dr Heaton-Ward's comments (*Bulletin*, August 1988) are very timely and warrant serious consideration by the College. An open-necked shirt and a casual, almost indifferent, attitude may be thought to put the patient at ease and may be the extreme, but they do not inspire confidence in the Tribunal's members. On more than one occasion I have felt embarrassed that I belonged to the same profession.

Tribunal offices obviously have problems in arranging hearings for Section 2 cases in view of the limited time available and it is accepted that the RMO may be unable to be present, but it would be helpful if a junior medical officer could represent the RMO rather than leave that responsibility to the ward sister or charge nurse.

I have sometimes found the RMO's report to be less informative and of less assistance than that of the social worker and I think the College has a responsibility to ensure that the standards of our profession are maintained and the interests of the patients protected.

The RMO is at liberty to ask the Tribunal President if a junior MO may attend the hearing as an observer, as part of training, and, to the best of my knowledge, such a request is always granted.

A. H. D. HUNTER

4 Springfield
Littleover, Derby

Guidelines for the training of general psychiatrists in liaison psychiatry

DEAR SIRS

I was interested to see that assessing deliberate self harm and patients in the Accident and Emergency Department are seen as part of the job description of liaison psychiatry (*Bulletin*, September 1988).

I have always felt that as psychiatric services become more community orientated and develop a more adequate response to emergencies outside the hospital, this emergency service should also cover the Casualty Department and deliberate self harm. In both cases the patient has usually come to attention because of problems outside the hospital and the skills involved in assessment and management seem to me rather different than those involved in assessing the psychiatric problems surrounding physical illness.

SAM BAXTER

Charing Cross Hospital (Fulham)
London W6