remained static; this occurred over a period of three years, when nationally hospital admissions were still rising. We quoted in illustration some extreme figures from official statistics and the figures for the Sheffield and the Liverpool regions were extreme whether one refers to Tables 3, 11 or 13 (1). This prompted the hypothesis that an increase in new out-patient referrals can prevent admission or prove an alternative to it. No 'claim' was made, and we advisedly used the term 'suggestion' to emphasize that these are 'no more than tentative and incomplete incursions into this difficult and relatively unexplored field' (2).

Out-patient care was investigated because '. . . relatively little is known about the patients so treated either descriptively or in terms of the care they receive. Nor is it known with any certainty how ambulatory treatment fits into the overall pattern of the psychiatric care of the individual' (3). This poverty of information is partly due to the difficulty in collecting reliable out-patient statistics and officially published figures are at best a rough guide. To quote Baldwin (2) '. . . the methods of collection are almost always disparate, idiosyncratic and of doubtful consistency' and '. . . the methods of data handling are . . . almost wholly dependent on clerical manipulation and so subject to unduly large human error'. In particular, the definition of a new out-patient varies from hospital to hospital. Forsyth and Logan (4) found that a patient who attended for follow-up immediately after discharge from hospital was counted as a new out-patient in about one-half of hospitals and as a repeat attendance in the rest. Similarly, some hospitals restrict the term 'new out-patient' to the first-ever attendance, while others apply it to the first of any new episode of out-patient care. The hospital returns sometimes show the number of patients booked and not the number of actual attendances. In-patient statistics are less subject to these vagaries and here the commonest source of error is probably 'double-counting', i.e. a patient transferred from one hospital to another will appear in each hospital's return and be counted twice (4). It is obvious that these figures are not suitable for statistical treatment such as used by Morgan and Compton: product-moment correlations and significance tests cannot be more reliable than the data from which they are derived. All that can be said is that official statistics reflect trends which should be investigated by collecting data in a given area and according to operationally defined criteria that are strictly adhered to. This we have done, reported our findings and discussed some possible explanations for them. They are confirmed by the findings of the Aberdeen psychiatric case register (2): '. . . the increase in extra-mural initial consultation was accompanied by a reduction in demand for in-patient care. It may be surmised that the one was the cause of the other' and 'hospitalization rates varied inversely with the amount of extramural service offered by the unit to which the patient was referred'. The problem remains complex and our results lead to further questions some of which we propose to explore. It is clear that availability of out-patient facilities does not automatically guarantee substitution of care, as public (including medical) expectations and practice do not change immediately (5).

If we understand them correctly, Morgan and Compton do not criticize our findings; they even list additional reasons to explain why in-patients and out-patients are to a large extent derived from different populations. They also accept that out-patient treatment can prevent admission or prove an alternative to it. However, they make a plea for more sophisticated methods 'to differentiate between the overlapping populations of hospital in- and out-patients'. The need for improved methods is only too obvious though 'sophistication' is becoming an overworked term, too often applied to soft data. We agree with Baldwin (2) that '. . . it is possible to discriminate between high and low in-patient demand characteristics in a number of ways using relatively simple data, and to distinguish patterns of care and trends which are of considerable value for the management and planning of services'.

In the absence of Dr. Evans, now in New Zealand, I am signing this letter.

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NEUROPSYCHIATRIC TRAINING

Dear Sir,

In September 1970, Sir Charles Symonds delivered the sixth Sir Hugh Cairns' Memorial Lecture to the

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Society of British Neurological Surgeons, in which he made a plea for more coordination in the education of neurologists, psychiatrists and neuro-surgeons.

This stimulating lecture, 'Tria Juncta in Uno', is now being printed, and it is felt that those who are now concerned with training in psychiatry might wish to read it. If they or any other of your readers would like to receive a copy, I should be glad to supply one on request.

JOHN M. POTTER,
Hon. Secretary,
Society of British Neurological Surgeons.

The Department of Neurological Surgery,
The Radcliffe Infirmary,
Oxford.

THE MEDICAL ART SOCIETY

DEAR SIR,

The Medical Art Society was founded in 1935 under the leadership of Sir Leonard Hill and Sir Harold Gillies for the encouragement of doctors who are amateur artists. Since then the Society has opened its doors to dental surgeons.

Except in the summer, monthly meetings are held in or near London. These vary in character and include demonstrations, discussions, and sessions when members' work is subjected to the comment and criticism of professional artists.

The highlight of the Society's year is its annual exhibition, when members are encouraged to submit for display work in any medium. The success of these exhibitions has lain partly in the encouragement they have given to the members themselves and partly in the fact that they have stimulated others to explore their own latent talents.

Experience of members of the Medical Art Society indicates that many doctors and dentists have artistic ability which awaits development and of which they are often largely unaware. It is also their experience that a little time 'stolen' from a busy schedule of professional responsibilities is almost unbelievably refreshing and salutary. A man who knows his own needs for self-expression and how to express himself is likely to be both more fulfilled in himself and more understanding of his colleagues and his patients.

For doctors, especially if they live in or within easy reach of London, membership of the Medical Art Society has therefore something important to offer, and we, as Officers of the Society, think it is timely to make sure that its existence and value are widely known.

The twenty-ninth Annual Exhibition will take place at the Archer Gallery, 303 Westbourne Grove, London, W.11 from 13–27 April 1972 inclusive (daily 10.00 to 17.00 hours, except Sundays). Information about membership of the Society and on how to submit works for exhibition may be obtained from the Honorary Secretary of the Society, Dr. M. B. J. McGrath, 55 Morley Grove, Little Parndon, Harlow, Essex.

ISABEL G. H. WILSON
for MAURICE RACKOW, *President*
BRIAN MCGRATH, *Hon. Sec.*
Medical Art Society.

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London, S.W.10.