applies to all types of treatment and not just operations (as in the case of F herself). Lord Brandon stated that: "The operation or *treatment* (my italics) will be in their (the patients') best interests if, but only if, it is carried out in order either to save their lives or to ensure improvement or prevent deterioration in their physical or *mental health*." Therefore, it could be argued that treatment of manic depressive psychosis with lithium in a woman with mental handicap is a treatment carried out in her "best interests" and that it would "ensure improvement or prevent deterioration" in her "mental health". In this case consent would not be required from either the patient or her parents.

Leaving aside the issue of mental handicap, since Dr Race's patient suffered from manic depression, which is a mental illness, she would be covered by the provisions of the Mental Health Act 1983. If it were felt that her mental illness was of a "nature or degree which makes it appropriate for her to receive medical treatment in hospital", then she could be detained under section 3. She would also need to satisfy one or more of the "health", "safety" or "protection of others" criteria.

However, if her parents objected to her receiving lithium they may also object to her being placed on section 3 and oppose the application. If the parents did this simply because they believed lithium to be a toxic drug, then the approved social worker would be able to apply to the county court, under section 29, for the appointment of an acting nearest relative on the grounds that the parents "unreasonably object to the making of an application for treatment". As a large body of medical opinion would agree that lithium is an appropriate treatment for manic depression, the parents' objection could be viewed as "unreasonable".

Either option would be likely to antagonise the parents, at least in the short term, but the best interests of the patient are our primary concern.

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Psychiatric practice and training in British multi-ethnic society

DEAR SIRS

The preamble to the College comments on its Special Committee Report (*Psychiatric Bulletin*, July 1990, **14**, 432–437) suggests that the work carried out by the Committee on distinguishing *ethnicity* (individual cultural identity) from *race* (the broader political articulation of ethnicity and the response to it) have been unavailing. Indeed the College appears to regard race simply as morphology and physiognomy in the 19th century manner; and its placing "racism" (sic) in quotation marks indicates that all that is required is careful practice and some goodwill. I am dismayed that all the hard thought of the Committee in teasing out the institutional practices of racism within psychiatry seems to have disappeared from this final statement.

On the question of terminology, I shall be happy to supply members with the glossary I prepared for the Committee (pages 73–75 of the report) and which we debated: it is of course a personal, not a canonical, document.

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'The Last Resort'

DEAR SIRS

I feel able to reply to Hugh Freeman's review of the television film 'The Last Resort' (*Psychiatric Bulletin*, July 1990, **14**, 416) because while I appeared in the film for a short period and I advised the producer, Mr Alan Hack, introducing some of our patients to him, I had no involvement at all in the overall presentation.

I feel that Professor Freeman has been unkind to a remarkable film. It is remarkable because a major psychiatric illness was presented with accuracy and sympathy, and a previously highly controversial treatment was introduced towards the end of the film in a calm and reasonable way. Throughout there were no emotional over-reactions and irrelevant controversies.

Professor Freeman complains that the programme was slow and therefore "many viewers may have voted with their feet . . .". It is surely impossible to present major depression in a dramatic way, with the audience glued to their seats, agog.

Professor Freeman is concerned that the viewer would not have "any idea of the number of operations done each year in Britain at present . . .". Has this any relevance to the film, which is more to do with a portrayal of the misery of chronic depression and its management?

We have received many letters from patients who have seen the film and they stress their relief that they observed somebody else so accurately experiencing their own particular distressing symptoms, which

they had felt were specific to them. Furthermore, the patients considered that the film showed their symptoms to the general population in a way that should convince people that the lady in the film, with her totally relentless depression, was suffering from a real and very incapacitating illness.

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Demise of the rotational training scheme

DEAR SIRS

Implementation of *Achieving a Balance* is leading to the demise of the rotational training scheme. This reform is intended to prevent the bottleneck between registrar and senior registrar by shifting it to an earlier stage of doctors' careers, the step from SHO to registrar. Few would disagree with the aims of *Achieving a Balance* but introducing the new scheme may also have an adverse impact on training. This has certainly been the case at the Maudsley where recent changes, in keeping with *Achieving a Balance*, have generated controversy, ill-feeling and a loss of morale among trainees.

An important consequence of these changes has been a loss of job security for junior doctors. Among the attractions of a career in psychiatry over recent years has been the continuity, job security and commitment to training of rotational schemes. In contrast, SHO appointments in some places are now for only 12 months. Apart from increasing the stress on doctors beginning psychiatry, this may interfere with the proper balance of general and specialist posts provided by a rotation and reduce the popularity of the speciality for medical graduates.

The other concern must be what sort of criteria will be used to decide on promotion to registrar. Some rotations use passing Part I of the Membership exam as a criterion. It may prove tempting for others to use the criteria which often determined promotion through the old bottleneck to senior registrar, which placed emphasis on research publications.

This may not be an appropriate way of judging SHOs with less than a year's experience of psychiatry as it risks devaluing the clinical aspects of psychiatric training. Many trainees will wish to spend at least the first year of psychiatry increasing their knowledge beyond that expected of a medical student and finding their way around the clinical practice of psychiatry and the politics of the multidisciplinary team. One would also hope that research started after this period would be of a higher standard and of more clinical relevance.

It seems important that the College consider the implications of *Achieving a Balance* for the attractiveness and quality of training in psychiatry. We suggest that SHO posts should be for a minimum of two years and that full weight should be given to clinical ability in deciding upon promotion to career registrar posts.

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Rotating junior doctors and care of the chronically mentally ill

DEAR SIRS

In the recently published 'Statement on Approval of Training Schemes for General Professional Training for the MRCPsych' by the Royal College of Psychiatrists (*Psychiatric Bulletin*, February 1990, **14**, 110–118), the issue of the type of training is raised. This should include a minimum of one year's experience in general psychiatry, as well as at least 18 months' experience in some of the other subspecialities. The statement also suggests: "Attachments of six to 12 months' duration probably strike the best balance between the needs of training and those of the patients for continuity of care". Although widely accepted, there does not appear to have been any critical research into the relative merits and pitfalls of junior doctors rotating.

The advantages of rotations are mainly in terms of training. It allows the junior doctor to experience working for several different consultants from different backgrounds and have direct experience of some of the sub-specialities. Hopefully, these experiences are integrated so that the trainee psychiatrist has a very broad-based foundation.

However, when one views the fact that a junior doctor may be changing every six months from the viewpoint of a chronic psychiatric patient, it does raise some problems. Firstly, the trainee may be young and rather inexperienced. At first he is not going to be able properly to appreciate the course of a chronic psychiatric illness or the potential responses to treatment and there is a considerable chance that he will become very defensive in his management. If this happens, the out-patient appointment can become a rather ritualistic ceremony. Secondly, the junior doctor will inevitably lack a detailed knowledge of the individual patient. This will cause several subsidiary problems as he will not be able properly to assess what is a realistic optimal level of functioning and will be unable to balance properly the relative merits and risks of reducing or stopping medication.