ethical committees when approving research proposals has been to permit nearest relatives to give consent in the patient's place. This solution is no longer viable as, by logical extension, a nearest relative would be able to consent to an HIV test on the patient. In the light of this statement, rather than face a General Medical Council hearing, we have just abandoned a study into a potential biological marker for psychosis.

We are concerned that this provision for blood tests may also apply to neuro-imaging and *possibly* to the application of structured interviews (as the latter may also reveal unsuspected, untreatable pathology, which currently seems to be one of the cardinal problems in HIV testing.) If this is the case, it is hard to see how significant research can be conducted on any but the worried well. One of us has written previously on the specifically psychiatric problems posed by HIV[2,3,4] and it would seem that the stagnation in research suggested in the last of these may become a reality if the present doctrine of specific consent is adhered to. Given the, in our opinion, justified importance attached by the College to research as part of training, we believe that the time has come for a consensus statement on the issue of consent. Backed by this, at least some research on our more severely ill patients may be able to proceed with the investigators secure in the knowledge that, if called before the Courts to justify their actions, they can be protected by the Bolam Test in that "a body of responsible medical opinion" has sanctioned their acts – at the moment, all research on patients whose judgement is impaired places the investigator at risk of litigation.

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Mixed marriage and stress

DEAR SIRS

In Britain today there are more than two million immigrants from the new Commonwealth and Pakistan. There is little doubt about the multi-racial status of present British society and the resulting enculturation. I have seen both in adult and child psychiatry the increased vulnerability of an individual to a psychological breakdown because of the complex dynamics of a mixed marriage. Such a marriage has to resolve a variety of personal, social, political and cultural conflicts if it is to succeed and create a healthy family. It is further complicated by the addition of children who have to grow up at times in an immense state of confusion about their identity and sense of belonging.

Birmingham has a high concentration of ethnic population and therefore one has more opportunity to see the problems associated with mixed marriages. I feel quite strongly about a role for preventive psychiatry in this field, and the increasing need for a counselling service for this particular population. I am at present conducting a survey of mixed marriage couples and hope to be able to publish the results soon to emphasise the need for a specialised counselling service. I would welcome the views of my colleagues on the subject and of any problems they might have encountered with this population in their clinical practice.

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Bipolar affective disorder and child psychiatry

DEAR SIRS

The predominant theme of the Residential Meeting in the Section of Child and Adolescent Psychiatry was childhood depression and bipolar affective disorder. As a relatively inexperienced diagnostician am I mistaken in detecting signs of bipolar affective disorder within the Section itself?

In the depressive phase, the pervasive feeling of hopelessness and helplessness in response to threats and cuts in child and adolescent psychiatry is experienced; in the manic phase, distressingly raucous and ribald laughter that was provoked by Dr Skuse's video recordings of 'abnormal feeding patterns'.

What is there to learn from the Section Meeting about the management of this condition? Should I follow Professor Taylor's example and initiate intensive investigations to reveal an underlying organic pathology? Or take Professor Graham's approach and try and understand these reactions as an understandable response to everyday suffering?

We practise in difficult times; like Dr Skuse's families it seems that we regard deprivation and decay as

inevitable. Are we equally unable to look beyond our awfully familiar surroundings and see the world outside? Or can we, as they so painfully did, look at ourselves and the way we feed our infants.

My diagnosis was wrong – these are the familiar mood swings of chronic political and spiritual malnutrition. I fear that whilst we feel unable to address the political and social issues that beset us, the condition will be untreatable.

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'Psychiatric Bulletin'

DEAR SIRS

For some years the *Bulletin* has been the orphan of the *Journal* of the Royal College of Psychiatrists. Neglected, unattractive and poorly nourished, it is not surprising that it failed to thrive. There have been occasional achievements; debates on matters such as the political abuse of psychiatry and community treatment orders were pertinent and persuasive, the correspondence columns have an occasional liveliness. Yet the criticism remains that the style of the *Bulletin* has been pedestrian and the content has rarely reflected the challenges which psychiatry now faces.

The editors must have shared some of these concerns, for the *Bulletin* has been re-vamped with a more attractive cover. But the layout and typography remain dreary, and the opportunity of re-casting the *Bulletin* as a stimulating and informative periodical has been lost. One proposal in particular should cause readers great concern.

On the first page of the October 1988 issue, Professor Freeman argues that the *Bulletin* is a scientific journal and that it will gain in status by increasing its academic content. Furthermore, articles which are accepted by the *Journal* and yet regarded as of lesser international interest may be relegated to the *Bulletin*. He vainly asserts that "this does not imply a less favourable view of their quality".

In the first place, few will share the view of Professor Freeman that the *Bulletin* is equal in status to the *Journal*, and that on past performance it is valid to regard it as a scientific publication. Papers appearing in recent issues of the *Bulletin* have been worthy commentaries and discussions on current themes, but have rarely approached the usual standards of peer-reviewed publishability.

Secondly, the proper function of the *Bulletin* may be regarded as reporting on aspects of current psychiatric practice, stimulating debate and summarising College news and views. There are many ways in which this mix could be invigorated, such as commissioning articles from lay critics of the profession, and by cultivating a greater awareness of the relationship between psychiatry and the society it seeks to serve. An increase in the number of scientific papers is likely to have the effect of stultifying the *Bulletin*. Is this what the readership wants?

Lastly, it's debatable whether the *Bulletin* should contain any peer-reviewed articles. The natural home for papers which reach the usual standard of scientific publishability is the *British Journal of Psychiatry*. If, having reached that standard, some papers are then regarded as dealing "primarily with circumstances in the UK or Ireland" and relegated from the *Journal* to the *Bulletin*, then this is hardly likely to increase the prestige of either. (It also seems curious that a Journal with "British" in its title has an editorial policy which explicitly rejects some articles derived from research in this country).

These matters should concern many of those interested in the welfare and public presentation of British psychiatry. By rejecting the opportunity for radical change, the editors have decided to present the *Bulletin* in a style which can only support the views of those who argue that psychiatrists are insular, divorced from the concerns of the community, and unwilling to court critical opinions.

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Hospital closure – an obituary postscript

DEAR SIRS

Retirement coinciding with closure of a large hospital is a potent brew for nostalgia. Sorting accumulated papers spanning three decades proved to be a lengthy and evocative process, recovering buried memories of brave new ventures and battles lost and won. In Warwick, one had commenced a consultant career by opening a purpose-built child guidance clinic and regrading to informal status several hundred County Mental Hospital patients, all of them compulsorily detained before the 1959 Mental Health Act was implemented. While still there, nearby Coventry celebrated the rebirth of its Cathedral in the ruins of the old with the première of Britten's War Requiem, which I attended.

After a subsequent 25 years in Kent, progressive dilapidation and demolition of its buildings and