My own view is that the Advisory Service should in fact be strengthened with statutory powers, both to restrain the stiffling effect on the development of conterminous district services due to the voracious demands of academic departments for staff, the justification for which would appear to be patient flow figures which largely reflect the absence of a local service in the deprived conterminous districts as well as the need to promote adequate provision of Local Authority resources for the mentally ill by those Authorities which would appear to be reluctant to countenance the development and provision of a truly comprehensive mental health service which reflects current models of good practice.

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DEAR SIRS

The letter from the Director of the Hospital Advisory Service (*Bulletin*, May 1986, **10**, 115) and his subsequent article (*Bulletin*, June 1986, **10**, 145–6) enshrine some misapprehensions about its approach.

His claims that the HAS 'does not hold strong beliefs' and that 'there is no HAS philosophy' are surely disingenuous. Its organisation is based on belief in a multi-disciplinary approach, which he vigorously reaffirms, that is no less a philosophy for being by now conventional. A range of beliefs such as that 'psychiatry is essentially a community speciality' underpin other aspects of its activities and inevitably so; it is hard to see how it could function without what is in effect a philosophy, however loosely articulated.

Equally, the claims that HAS team members have no axes to grind and are unencumbered by local history and politics conflict sharply with the experience of many of those visited. Indeed, the last few lines of his letter confirm how easy it is to become sucked into the host District's politics; and they are certainly not unencumbered by the history and politics of their own districts.

It is surely time for the HAS to accept that a range of assumptions inevitably underlie its teams' activities, rather than continue to pretend to itself and others that none exist. The Director of an organisation that expects others to examine their preconceptions should not be so complacent about its own as to suggest it has a 'proven system' and to offer no choice except more of the same or replacement by an inspectorate.

The third alternative is surely for the HAS to stimulate reviews, debate and research on themes which underlie its approach and on the effects of its interventions on the development of mental illness services. Its 'direct line' to ministers might appropriately be used to fight for the resources required.

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ECT on OPD basis

DEAR SIRS

It is surprising to learn from Dr Snaith's letter (*Bulletin*, March 1986, **10**, 55) that out-patient ECT is administered sparingly in the UK because of fear of mishap, disaster and so forth. I wish to support Dr Snaith's views and say that, in India, ECT is administered on an out-patient basis at most centres. In my centre, which is a postgraduate department, modified ECT has been given on an out-patient basis for over 25 years without mishap. Written instructions for pre- and post-ECT care are given to patients and relatives, who follow them well, even though less educated than those in the UK.

Out-patient ECT is more acceptable to patients and their relatives because admission, which has social stigma in our country, can be avoided. Thus many early cases can derive its benefit. Moreover in India out-patient ECT is less expensive than in-patient ECT where there are a very limited number of psychiatric beds (25 000 only) anyway.

Hence for various reasons such as more acceptability, low cost, wide coverage and practically no risk, out-patient ECT merits more use. Otherwise many patients in the community will be deprived of an effective and safe therapy.

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MRCPsych Preliminary Test

DEAR SIRS

I write to express my increasing disquiet with the MRCPsych Preliminary Test. Not one of the junior doctors at my hospital passed this exam last time round. This might not have caused much surprise seven years or more ago when it was difficult to attract good doctors to work in large mental hospitals. However, times have changed; Long Grove is now linked to St George's Hospital for general psychiatric training and as a consequence of this link with one of the most highly rated training schemes in London, we are now able to attract many outstanding young doctors. In addition, the College has been most influential in increasing the attractiveness of psychiatry as a speciality, with the result that many of the best and brightest products of British medical schools are opting for a career in psychiatry.

So, if our trainees are so talented, enthusiastic, hard working and conscientious, as I believe they are, how is it that not one of them passed this Preliminary Test?

The only feasible explanation seems to be that the proportion of candidates who 'passed' the exam is fixed, so that regardless of standards, only a certain number of people can be allowed to get through each time. If true, I believe this situation to be unfortunate, if not demoralising and potentially destructive.

When the College established the MRCPsych and Preliminary Test to supersede the DPM it essentially modelled it on its predecessor. The ideal of the Preliminary Test, as I understand it, was to stimulate study of the basic

sciences underpinning psychiatry and act as a hurdle to weed out those who weren't up to further training. The result of failing so many people is that trainees spend more and more time during their clinical training in studying and revising material for the Preliminary Test. This inevitably prevents them from committing themselves fully to clinical studies and their training suffers in consequence.

So can anything be done? I would like to suggest two possibilities. Ideally the Preliminary Test should be abolished altogether. Far from being a small hurdle it has taken on the proportions of Bechers Brook. Why not have one exam in which basic sciences, psychopathology and clinical matters are all integrated together? But perhaps this is too radical a step to consider, so as a second alternative why not establish a pass mark so that however many people reach that mark will be deemed to have passed the exam. If everyone passes, Hurrah, it means that training courses and standards generally have improved.

I am deeply concerned that the examiners may be out of touch with what is going on at the grass roots and I would be very interested to hear the views of other readers.

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Psychiatry and its stigma

DEAR SIRS

I was recently in Washington DC where I attended the 139th Annual Meeting of the American Psychiatric Association (APA). I was greatly influenced by the amount of effort being invested by the APA into a campaign to reduce the stigma associated with mental illness and the prejudice shown by society in general and the rest of the medical profession in particular toward psychiatrists. The incoming president, Dr Robert O. Pasnau MD, stressed that, aside from the problems of medical liability, the new DSM IIIR, and the allocation of a reasonable Federal budget toward mental illness, he regarded the question of the stigma of psychiatry as a priority issue. The allocation of two full symposia on this topic together with a major lecture by Jack Hinckley (founder of the American Mental Health Fund following the shooting of President Reagan by his son) reflected this concern. An impressive array of weaponry has been assembled in the APA's armamentarium to combat this problem. A major publicity campaign will soon be mounted on radio and national network TV, aiming to de-mystify mental illness. The securing of a 9½ million dollar aid package from the US Advertising Council adds considerable financial weight to this programme, which is backed up by a subsidiary campaign on 'depression and its ART—awareness, recognition and treatment'. Congressmen, media personalities, prominent public figures and professional marketeers have all been recruited to help. The National Association of the Mentally Ill and the American Medical Health Fund have promised support. The birth of the National Association for Depression and manic-depressive illness on Capitol Hill while all this was being discussed in the conference added weight to the APA's argument.

Finally, and perhaps most important of all, the APA is plannning a physician's awareness campaign to try and alter the way our colleagues in other specialities regard psychiatrists. The message is simple. The stigma attached to psychiatry has hindered effective psychiatric care and caused anguish to American psychiatrists for too long, and the APA has determined to try and rectify the situation. Whilst some of their tactics may not be applicable to the UK (although professional marketing consultants are now employed by all three major political parties), the basic need for action on this issue clearly is, and I would hope that in due course the Royal College of Psychiatrists would generate its own initiative. It is high time that the remark 'You're the only sane psychiatrist I know'[1] became an echo from the past.

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REFERENCE

[1] FINK, Paul J. (1984) You are the only sane psychiatrist I know. *Journal of the American Medical Association*, **5**, 611.

Psychoanalysis: natural or human science?

DEAR SIRS

I was very interested to read Carola Mathers' article in the recent *Bulletin*[1] and agree with her that 'as psychiatrists we need to keep open minds as to what constitutes scientific activity' and also, 'that to consider levels of explanation unfamiliar to us as being nonscience . . . is to impoverish our understanding . . .'

The reader will be familiar with Jaspers' claim[2] that psychoanalysis is a discipline using empathetic understanding which mistakes itself to be a causal science similar to the natural sciences. I want to propose here (by-passing a more fundamental critique of Bhaskar's theory of science which would be better left to a philosopher) that Bhaskar's 'transcendental realism'[3] leads to a rather similar conclusion: Bhaskar argues that causal explanations are equally applicable in the natural as in the human sciences. The fundamental difference between the two lies in the way the 'generative mechanisms' are being identified: while in the natural sciences these mechanisms can be directly observed or experienced by their effects (like in the case of a magnetic or gravitational field), in the human sciences they have to be identified by an hermeneutic analysis. Whether conscious (or unconscious) reasons are *causally effective* or mere *rationalisations*, or even pretended, can only be determined by comparing the given reason with its situational context, the history and personality of the subject, and in negotiation with him or her. In this process of empathetic understanding as described by Jaspers,[2] the particular reason is illuminated by its situational and psychological context—in

MRCPsych Preliminary Test

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