length of addiction. It is not possible to argue from a single case, nor, perhaps appropriate to bet on such a serious issue. We are currently preparing a report on more than 30 addicts treated according to our protocol, and most of our 'chaotic' addicts have also had healthy babies at term.

Addiction to injection may be less important now in the climate of anxiety about HIV infection. However, injectable methadone is not licensed for intravenous injection, and causes thrombophlebitis and the risk of septicaemia when used in this way. The few patients on injectable methadone in our series have been willing to change to oral medication when the dangers have been explained.

Her statement that it can be 'morally responsible' for the parent to treat her own child with opiates is in itself so irresponsible as to require no further comment, especially in view of the increased incidence of neonatal death in these infants. Paediatricians use chlorpromazine or phenobarbitone to treat the infants because these are relatively safe in the neonate, and do not have the low lethal threshold of opiates. Surely few lay people are experienced in neonatal pharmacokinetics, and infant deaths from opiate poisoning have been reported.

That parents do treat their babies in this way because of 'lack of confidence in their professional advisers' is no excuse. The cornerstone of successful treatment is a trusting relationship between doctor and patient. The plan of treatment is openly negotiated, and the reduction carried out with the patient's full agreement. Good ante-natal care, social support, and flexibility of dosage are part of the total plan.

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Professor Edward Anderson

DEAR SIRS

I was very interested to read the interview with Professor Rawnsley which appeared in January's *Bulletin*. I was particularly pleased to note that he has set the record straight regarding Professor Anderson, who in my opinion also has been much under-estimated. I think Anderson must be credited with a large share of the interest that has developed in recent years in the work done by German-speaking psychiatrists, particularly such figures as Kurt Schneider. He also played a considerable role in making known to us the importance of phenomenology in psychiatry and in particular the contribution of Karl Jaspers. He had a great influence on postgraduate students in Manchester and although he worked in a very modest department, his teaching had a profound and lasting effect on British psychiatry, which he enriched with the treasury of continental scholarship.

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Canadian qualifications for British psychiatrists

DEAR SIRS

Further to our recent correspondence on the above subject (*Bulletin*, January 1988) it has come to our attention that the Canadian Royal College of Physicians and Surgeons has recently implemented a further prerequisite for non-North American psychiatrists in respect of their eligibility to take the FRCP (Psych) examination. It is now required that all non-North American psychiatrists complete a one year rotating internship (in UK terms house officer status) of the North American type, in order to attain eligibility for this examination. This is in addition to the other mandatory requirements of passing a North American screening examination and having one's psychiatric training assessed by the Royal College. The need for this internship, however, may be bypassed if one passes an oral examination of clinical competence organised by a Canadian medical school. While this examination of 'clinical competence' is now available for non-North American psychiatric trainees in Canadian residency programmes, it is not clear, as yet, as to whether physicians outside such residency programmes will be able to avail themselves of this assessment.

We regret that this information was not present in our earlier letter. It does, however, present yet a further significant hurdle to UK psychiatrists achieving Canadian psychiatric qualifications, which we feel British trained psychiatrists considering a career in Canada should be aware of.

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The need for asylum

DEAR SIRS

I cannot rival the eloquence of Drs Garelick and Abrahamson in their complementary papers in February's *Bulletin*. I do, however, wish to support fully the ideas they put forward.

Dr Garelick's account of the local planning process makes extraordinary reading with regard to the lack of weight given to clinicians' opinions in the process. Both he and Dr Abrahamson make a compelling case for the need for asylum as part of the psychiatric service, in turn Dr Abrahamson suggests that the apologetic tone of the consensus statement from the Third Kings Fund Forum is ill-judged.

The reality is that many patients (not clients, consumers or recipients) are crippled by severe psychiatric illness (not merely distressed). I much prefer the medical paternalism which is prepared to state what such patients need (in some cases long-term hospital asylum) to the arrogance of the self-styled patients' advocates who claim to know what they want without benefit of any face-to-face contact.

We are fortunate in Scotland in that whatever difficulties

Professor Edward Anderson

N. Berlyne

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