Collacott & Cooper would care to contribute to these.

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The inappropriate question syndrome

DEAR SIRS

Drs Madeley, Mumford & Biggins have, I hope, amused the readership with their witty letter (*Psychiatric Bulletin*, October 1990, **14**, 629). There is a simple behavioural management technique for the inappropriate questioner which they do not mention; however, it requires an enormous amount of cheek. The presenter should say in a confident and self-assured manner, "with regard to this point, we should always remember the proverb which states that the greatest fool may ask more than the wisest man may answer". Such a consequence should fail to reinforce inappropriate questioning behaviour, possibly in the short and long term, a stunned silence being the most likely outcome. Clearly this drastic technique must only be used for the most extreme exponents of the inappropriate question syndrome.

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DEAR SIRS

Drs Madeley, Mumford & Biggins' description of 'the inappropriate question syndrome' (*Psychiatric Bulletin*, October 1990, **14**, 629) is well received. We recommend the following preventive strategy. At the end of a presentation, the chairperson invites each member of the audience to turn to his/her neighbour and voice any thoughts about the paper for five minutes. During that time, anyone with a burning question may approach the speaker at the front of the hall and the next presenter can be making necessary preparations.

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Psychiatric liaison service

DEAR SIRS

Having just completed a nine-month post as psychiatric liaison registrar at Westminster Hospital, I read with interest the article by Gourdie & Schneiden (*Psychiatric Bulletin*, September 1990, **14**, 548–549) which recounted their experience in a similar post at another London teaching hospital, University College. It appears that the main difficulties they encountered in their work were lack of time for adequate follow-up of deliberate self-harm patients and little opportunity to build up a fully involved psychiatric liaison service on the general wards. Both these problems stem from the disproportionate amount of time taken up by psychiatric assessment of deliberate self-harm patients in the Accident and Emergency Department and on the wards.

Every trainee in psychiatry gets a great deal of experience in emergency assessment of patients and assessment of suicide risk during their on call duty at night and weekends. A training post in liaison psychiatry should concentrate on experience which cannot be gained elsewhere. Reducing the amount of time spent on the assessment of deliberate self-harm patients would allow the trainee to benefit from a broader experience of liaison psychiatry, such as that described by Foster, 1989. In addition the general medical and surgical wards could expect an improved liaison service. But how can this be achieved without resorting to the duty psychiatrist?

Research which found that non-psychiatrists were able to make safe and reliable assessments of attempted suicide patients (e.g. Newson-Smith & Hirsch, 1979; Catalan *et al*, 1980) resulted in a change of policy as recommended by the Department of Health and Social Security (1984). The new guidelines acknowledge that adequately trained personnel (e.g. general physicians, social workers and psychiatric nurses) can undertake the psycho-social management of deliberate self harm patients. Consequently an increasing number of hospitals are changing their approach to the care of these patients.

At Westminster Hospital a system of joint management has been developed. All deliberate self-harm in-patients and some of those presenting in the Accident and Emergency Department are seen by one of the three social workers attached to the Carlyle Unit (deliberate self-harm unit). As most of our patients present with social problems or interpersonal conflicts (which often require follow-up counselling and advice) this initial contact with the social worker is both therapeutic and cost effective in terms of time and resources. The liaison registrar is available for consultation and is normally asked to further assess approximately half of all the patients seen. Those requiring psychiatric follow-up are referred to the appropriate services by the trainee. The social workers and liaison registrar meet with the consultant (liaison psychiatry) once a week to discuss cases seen and further management plans.

This system is efficient in that it makes the best use of available resources with minimum duplication of work; it also allows the trainee more time to pursue areas of interest within the specialty of liaison psychiatry. However in a large general hospital the registrar may find that he/she has to spread himself

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very thinly throughout the wards, resulting in a poor liaison service for staff and patients and a less than adequate experience of the specialty for the trainee. At Westminster this problem has been partially resolved by restricting the liaison attachment to a limited number of departments (e.g. the ward for HIV patients) which allows the trainee to offer and experience liaison psychiatry to a more fulfilling degree. Of course this means that other departments in the hospital suffer from the lack of a liaison attachment and have to rely on referrals to the local psychiatric hospital. Unfortunately, this situation is typical of the state of consultation and liaison psychiatry throughout Britain today (Mayou *et al*, 1990). If resources allowed, a fully qualified multi-disciplinary liaison team could be developed, resulting in a better service for all hospital staff and patients, and a better training for the liaison registrar.

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Thirty-six questions for the MRCPsych

DEAR SIRS

As a result of the work done with trainees preparing for both parts of the MRCPsych examination, and two groups of senior registrars, over the past five years and a bit, I have worked out a set of 36 questions which have had a very interesting history: every candidate who has successfully worked through *all* of these questions, and wholeheartedly participated in the related clinical audits, has been successful in the Part I or Part II MRCPsych Examination *immediately following* this training programme.

As this training programme has been so helpful to quite a few doctors, I would like to share it with all, trainees and tutors alike, and hope that this contributes something of value to education and training in psychiatry.

The questions

1. What is psychiatry all about?
2. What do you understand by the expression 'disorders of the mind'?
3. What are the functions we attribute to mind?
4. How does the brain work?
5. What is the relationship between brain physiology and the functions we attribute to mind?
6. How do we think that the mind develops?
7. How may disorders of the mind manifest?
8. What are the causes of mental disorders?
9. Are mental disorders diseases?
10. Why do we classify mental disorders?
11. How are mental disorders classified?
12. Do mental disorders manifest in the same ways all over the world?
13. How would you arrive at the conclusion that a person is suffering from a mental disorder?
14. What do you know about the individual psychiatric syndromes?
15. What are the physical treatments for mental disorders?
16. What are the physiological effects of the physical treatments?
17. How do the physical treatments produce their therapeutic effect?
18. What are the psychological treatments for mental disorders?
19. How do the psychological treatments produce their beneficial or adverse effects?
20. How did these psychological treatments become established?
21. What are the social and environmental treatments for mental disorders?
22. How do these social and environmental treatments generate a therapeutic effect?
23. What are the settings in which these various forms of treatment – physical, psychological, and social and environment – may be given?
24. What people carry out the treatment of mental disorders, and how did they get involved in this sort of work in the first place?
25. On what grounds would you admit a mentally disordered person into hospital?
26. How does being admitted into hospital get patients better?
27. How could being in hospital make patients worse?
28. How would you prepare a person for return to meaningful living in the community after a period of treatment in hospital?
29. What continuing help is available for those who have been discharged from hospital?
30. What conditions may present as emergencies in the field of psychiatry?
31. What do you know about the Law that regulates the admission, treatment, discharge and the management of the property of people suffering from mental disorders?
32. Are mental disorders preventable?
33. What becomes of the mentally disordered in the long run?
34. How have we acquired the body of knowledge we now possess about mental disorders?
35. What do managers do, and what is the relationship between them and the clinicians?

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