for Section 3 should this be necessary.

Unfortunately, this course of action was not available to us and our patient died, her rights to remain untreated uninfringed.

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Future of the consultant in psychiatry

DEAR SIRS

In his article (*Bulletin*, July 1984, **8**, 122–23) Professor K. Rawnsley expressed the need for the re-appraisal of the role to be played by consultant psychiatrists in the future. This is an excellent, progressive idea which will abolish the present isolation and sectorization of the different branches of psychiatric practice.

Professor Rawnsley advocated that child and adolescent psychiatry be kept separate from other specialties, possibly in an attempt to avoid labelling children as 'psychiatric' cases. These specialists should work with paediatricians in order to avoid this problem.

So far as adults are concerned, psychiatrists are to declare their special interest in some sub-specialty. I would suggest two main sub-specialties as follows:

Organic psychiatry: incorporating the psychiatry of mental handicap; the psychiatry of old age; and organic brain diseases such as epilepsy, dementia, genetic disorders, etc.

Functional psychiatry: incorporating neurosis; personality disorders; depressive illness; psychosis; alcoholism and drug dependence; psychosexual disorders; and forensic psychiatry, etc.

The two types of psychiatrist will work from the same base hospital and will have opportunities to develop research interests, all necessary facilities being available to them. Working in close liaison, they will be able to provide a high standard of psychiatric care for their patients.

I hope that the College will take note of this suggestion and negotiate with the DHSS in order to implement reorganization in the near future.

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Registrars' training in mental handicap

DEAR SIRS

It is encouraging to see that the College has been very particular about the requirement of mental handicap training for registrars in the rotational training schemes. However, it is important for the College Assessors to note that the training should not become so inflexible and structured that the service part of it is disregarded. This seems to be happening to a greater or lesser extent to many training programmes, resulting in certain deficiencies in training, and, equally importantly, adversely affecting the quality of care and treatment of patients. I consider, and many of my consultant colleagues may agree, that in-service training is a vital part of any registrars' training programme. Today's trainees are tomorrow's potential consultants, and must learn a balanced and practical view of the work in this field. This is particularly relevant to the mental handicap field, as this has been a deprived and deficient specialty and most of the consultants in this field are overworked and under great stress and would find the added burden of training difficult to cope with if not linked with in-service training.

The College has done a great service by recognizing the clinical and training needs of this specialty as part of overall psychiatric training, and I am sure would be perceptive enough to demand from the trainees equal effort and input in the in-service aspects of the training, which includes a major share of clinical work with patients. Otherwise too much structuring and 'spoon feeding' may result in a not so well equipped trainee at the completion of the training requirement. I am expressing this concern both as a participant and observer in the registrar's training programme.

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'Clomipramine Challenge Test'

DEAR SIRS

Following Dr A. G. W. Holmshaw's letter (*Bulletin*, April 1984, **8**, 76), I would like to report a patient who developed psychotic symptoms three weeks after Clomipramine administration for her depressive illness.

A 28-year-old unmarried secretary was admitted with a three-month history of depression with suicidal intent, following her job change. She was started on Clomipramine 75 mg nocte which was increased to 150 mg nocte after a week.

Pre-morbidly she used to be a shy, withdrawn person who was not a good mixer. Three weeks following her admission when she went home on weekend leave after a slight improvement she started to behave very strangely. She became mute and started shaking her head, arms and legs. She then talked about an imaginary boyfriend. She giggled inappropriately and believed she could hear her own thoughts. Clomipramine was stopped. She still remains odd; smiling inappropriately (almost continuously) and shows emotional blunting.

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