Sir: Dr Al Rubaie's point is well taken. We had certainly not intended to reify the notion of "the unconscious", nor did the therapist or intake team wish to exonerate themselves from clinical responsibility by attributing actions to a notional 'unconscious' rather than to a freely chosen clinical decision.

However, we were trying to draw attention to the fact that clinicians are often unwittingly influenced by forces – perhaps most usefully seen in terms of transference and counter-transference – that are outside of their awareness, and that there are interesting overlaps between the field of ethics and such dynamic understanding. So far from absolving ourselves of responsibility by invoking such forces, we suggest that, by becoming aware of them, better clinical and ethical judgements can be made.

JEREMY HOLMES, *North Devon District Hospital, Barnstaple, Devon EX31 4JB*

Sir: Holmes *et al*, (*Psychiatric Bulletin*, August 1994, **18**, 466–468) give a valuable demonstration of the utility of philosophy to psychiatry, which they themselves perhaps underestimate.

Justice has indeed been a rather neglected area of psychiatric medical ethics, and its scope extends far beyond resource allocation. For example, Newth (1994) describes the potential for injustice in the treatment of doctors who suffer mental illness. We currently have no way of dealing with this, perhaps because of the countertransference dynamics Holmes *et al*, describe.

Recent philosophical work may help to resolve one dilemma they posed, that of autonomy and unconscious determinism in psychotherapy. Both psychiatrists and philosophers have usually assumed that our decisions to act are grounded on our desires and our beliefs. This certainly does lead to a problem of competency in psychotherapy, as desires and beliefs in that setting may be determined involuntarily because of unconscious processes. However, Bratman (1987) has demonstrated that our intentions to act are phenomenologically distinct from both desires and beliefs. He considers intentions are conscious, and involved with planning our decisions. Furthermore, he suggests that they may have a role in preventing incongruent desires and beliefs diverting our plans. They would thus act as a 'filter of admissability' for unconscious desires and motivations. As intentions are conscious and rational, they support autonomous and responsible actions. It may therefore be that our competency in psychotherapy is conferred by our intentions, not our desires or beliefs. Both philosophical and phenomenological research would be needed to test this speculation.

Holmes' *et al*, discussion of philosophy and ethics can be readily extended to identify a need for new directions in both practice and research. So, philosophical medical ethics can do more than reveal the world as a spectacle, as they claim. It can both study and seek to change it.

BRATMAN, M. (1987) *Intentions, Plans and Practical Reason*. Cambridge, Mass: Harvard.

NEWTH, S. (1994) Depressed doctors must 'come out'. *BMA News Review*, August, 26.

D. M. FOREMAN, *University of Keele, School of Postgraduate Medicine, Stoke-on-Trent ST4 7QB*

## Group therapy for adults with a learning disability

Sir: We read with interest the article by Dr Procter on group therapy with pre-adolescents (*Psychiatric Bulletin*, August 1994, **18**, 485–486) and endorse the value of running groups under supervision for psychiatric trainees.

We recently co-facilitated a seven week group for adults with a learning disability using active techniques under the guidance of a qualified psychodrama therapist. We wanted to provide an opportunity for adults who were in the process of broadening their horizons to meet as a group and share experiences. It had become clear that there were few opportunities for such people to meet new faces outside of the work or home environment. Our leaning towards active techniques came in part from a wish to make the sessions enjoyable for the group members as well as from our own personal and training experiences.

Our aim was for group members to be able to identify feelings within themselves brought up by being in the group as well as to recognise feelings existing within others. In addition we hoped that regular attendance would increase each individual's confidence and level of social skills. Each week one of us started the session with a warm-up exercise and then handed over to the other to complete the main piece of work and end the session. We discussed themes for each session in our weekly supervision but tried to be flexible and change our plans as the need arose.

At the end of the group we felt that we had achieved our aims and the positive response from the members has encouraged us to consider using a similar approach in the future. We learnt a lot both about the practical aspects of setting up a group and therapeutic factors within one. We were also left with much food for thought about the effect that an individual's developmental level may have on his capacity to understand the emotions of another and the



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need for therapists to modify role play techniques accordingly.

GILL SALMON and SHIRLEY ABELL, *Slade House, Oxfordshire Learning Disability Trust, Oxford OX3 7JH*

## Audit staff and their role

Sir: I was dismayed that Cook & Langas' review of audit (*Psychiatric Bulletin*, August 1994, **18,** 477) did not mention audit staff at all. I am sorry if the doctors do not have access to an audit department, but if they did many of their concerns would evaporate.

I have been a medical audit officer in general psychiatry for two and a half years. My whole *raison d'etre* is to work on behalf of doctors (not managers, administrators, purchasers) in setting up and carrying out audits. The main duties of audit staff are dataform design, retrieval of notes, data analysis and presentation – in other words, we take care of the administrative parts of an audit that clinicians do not have time to do. In some cases we actually do the audit as well, which educates us but not the trainees.

Audit staff have experience and skills in many different areas. Knowledge of who to see and where to go to find information in such a large organisation as the NHS is invaluable. They should also have access to, and be competent in the use of, a computer, producing good quality forms, reports and presentation materials.

So, we are here, please use us. Let's show that medical audit is effective before clinical audit arrives in earnest and audit manpower and resources are stretched to the limit.

PAUL KIRBY, *Medical Audit Officer, St James's University Hospital, Leeds LS9 7TF*

## 'Age' should be included in the Trainees' Charter

Sir: I read with interest the contents of the Trainees' Charter (*Psychiatric Bulletin*, July 1994, **18,** 440) in particular, Clause 12, "To be treated with the consideration and respect expected of a professional colleague irrespective of status, sex or race".

Several countries, including the United States and France, provide legal protection against age and discrimination. There is no specific legislative protection against age discrimination in the United Kingdom.

Age as a discriminating factor is now a national issue in the prevailing climate of redundancies and unemployment. Although not a major problem within the medical profession as a whole, age is often perceived as a discriminating factor by a subgroup of overseas qualified doctors settled in the United Kingdom, who tend to be older than the equivalent British qualified doctors. Like myself there are several 'older' trainees of all grades in psychiatry, especially from the ethnic minorities. Being 'older' sometimes hinders the proper consideration of an individual's skills, talents, experience and potential.

The Institute of Personnel Management (IPM) holds the view that "a national campaign is essential to raise public awareness and increase the understanding of employers, employees and their representatives about the harmful business and personal implications of age discrimination in employment". The implications of age discrimination, key facts on the subject and recommendations for reducing age discrimination are clearly laid out in *The IPM Codes of Practice* published in 1993.

The Gwent Community Health NHS Trust, of which I am an employee, has given due recognition to age discrimination by its inclusion in the Equal Opportunities Policy.

I feel strongly that 'age' should also be included among "status, sex and race" in Clause 12 of the Trainees' Charter. It would certainly be a significant step forward and should be considered by the Collegiate Trainees Committee, Dean and Court of Electors.

FATHIMA FAROOK, *Ty Bryn Adolescent Unit, St Cadoc's Hospital, Caerleon, Gwent, South Wales*

Sir: I would like to thank Dr Farook for these comments; we will give them careful consideration when we revise the Trainees' Charter.

STEFFAN DAVIES, *Chairman, Collegiate Trainees Committee*

## Need for information about appropriate prescribing

Sir: Mullen *et al*, (*Psychiatric Bulletin*, June 1994, **18,** 335–337) found a wide variation of doses perceived as equivalent among a survey of clinicians. They suggested that this finding was disquieting and that education in this area may be inadequate but the responses of the clinicians may partly reflect the differences that are apparent between various information sources. An important source of drug information is the pharmaceutical companies. Foster (1989) pointed out the recommendations on equivalence provided by these companies differ from each other and from the literature. Schulz *et al* (1989) reported equivalent doses varying by 20–50% depending on which company material was considered. That the BNF offers no guidance on equivalence between oral and depot medication



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