Correspondence

Attitudes of Staff and Patients to Psychiatric Admission Wards

DEAR SIR,

When I started to read this paper (*Bulletin*, Feb 1980, pp 22-25) I was puzzled by its use of anonymity for the author and hospital concerned; the results revealed nothing shameful. I became more worried when I realized that there was to be no attempt to describe the three wards sampled, even though the attitudes measured in any unit and the nature of its structure and functions are intimately interrelated. Moos and his colleagues at Stanford's Social Ecology Laboratory have for many years been systematically investigating these relationships.[1]

My main criticism, however, is one of the paper's implicit assumption that the wards surveyed are 'typical' admission units, so permitting the use of the results to make general recommendations. I particularly challenge whether these findings can be said to give any support to the suggestion that disturbed patients should be admitted to single-sex wards staffed by uniformed personnel (except, perhaps, in the actual hospital studied). I have, for example, recently described an acute admission unit (Street Ward Community, Fulbourn Hospital, Cambridge) which, by using a therapeutic community culture, contains all the disturbed patients admitted from its 'sector' in a mixed sex, uniform-free, open setting, without any seclusion room or locked ward back-up.[2]

Before recommendations concerning the optimum organization of any type of unit can be made, it is necessary first to learn how staff and patient attitudes are shaped by various ward programmes, styles of leadership, etc, and how these attitudes in turn affect function and results.

G. P. PULLEN
Consultant Psychiatrist

Littlemore Hospital,
Oxford.

REFERENCES

1 MOOS, R. H. (1976) *The Human Context: Environmental Determinants of Behaviour*. New York, Wiley. Interscience.

2 PULLEN, G. P. (1980) Communal medication. *International Journal of Therapeutic Communities*, 1, 1.

Rotational Training Schemes

DEAR SIR,

I read with interest the description of the two rotational training schemes in the December issue of the *Bulletin*, p. 190. One cannot dispute that they are examples of good current practice, but I am apprehensive that their standard will become the 'norm' which every hospital is required to meet, even though local factors make it impossible to do so.

There are many similarities between Exeter, its catchment area and the area covered by the Cleveland Area Health Authority. We serve a similar population and have similar Consultant staffing levels, with the addition of a Consultant in Adolescent Psychiatry who runs a sub-regional unit, and a Consultant in Forensic Psychiatry who runs an interim secure unit and will become responsible for the Regional Secure Unit which opens later this year, and we offer, I think, a wide range of experience.

St Luke's Hospital serves rather more than half of the catchment area and has recently been placed in Category 'A', whilst the two DGH units, which serve the rest of the area, have been placed in Category 'P'. It has been made clear that if we do not establish a Cleveland Rotational Training Scheme, the DGH units will lose approval and St Luke's will shortly follow them into oblivion.

My colleagues are eager to establish a rotational scheme, but between us we muster a grand total of two Registrars and one Senior Registrar, which establishment we have sought to increase, only to be turned down by the Central Manpower Committee, even in respect of a Registrar for the Regional Secure Unit for which we have funds. It must be admitted that we have some SHOs, but in a situation where the majority would have to remain in that grade for 3½ years we cannot attract candidates who are seriously pursuing a career in psychiatry.

I would be grateful if someone could tell us, in these circumstances, how we can meet the standard set by Exeter. I strongly suspect that the only realistic answer is a compulsory redistribution of Registrars away from those areas where they are to be found in plenty, but I doubt if the Consultants therein are prepared to make the ultimate sacrifice of giving up a Registrar. Still less do I believe that there is a Collegiate will to force them to do so.

Thus we face the prospect of unapproved hospitals in Cleveland, to which Consultants will not come and where services will then deteriorate to a point that will demand an inquiry, at enormous cost, by the DHSS in which those Consultants foolish enough to stay will be criticized for failure to show adequate leadership.

Needless to say, I am considering the possibility of an early retirement.

JOHN BLACKBURN
Consultant Psychiatrist

St Luke's Hospital,
Middlesbrough,
Cleveland, TS4 3AF.

Cuts in the National Health Service

DEAR SIR,

Mr Patrick Jenkin's letter to the President published in the *Bulletin* (February 1980) would be reassuring if only it matched the state of affairs seen in the District Psychiatric Services.