Family Day Unit present with severe emotional and/or behavioural disorders. This alone would seem to justify the involvement of a (child) psychiatrist in child abuse cases, both for assessment and treatment purposes.

(2) Dr Dunn appears to be unaware of a large body of work by child psychiatrists, social workers and allied child care professionals who have over the years attempted to establish reliable ways of assessing the likelihood of re-abuse (some of it summarised in[1]). To state, as Dr Dunn does, that we do not know what the behaviours are that may lead to rehabilitation, other than "not to abuse their children", shows a somewhat limited understanding: the actual act of abuse is not an isolated phenomenon but only one (though probably the most severe) symptom of inadequate or "dangerous" parenting.

(3) To suggest that the decision to return an abused child to his home "is essentially a moral problem" is worrying: whose morals anyway? Courts in fact request child psychiatrists to provide more objective information[2], not "pseudoscientific" or moralistic statements.

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References

[1] ADCOCK, M. & WHITE, R. (eds) (1985) *Good-Enough Parenting: A Frame-work for Assessment*. Practice Series 12. London: BAAF.

[2] BRITISH AGENCIES FOR ADOPTION AND FOSTERING (1984) *Taking a Stand: Child Psychiatrists in Custody, Access and Disputed Adoption Cases*. Discussion Series 5. London: BAAF.

Psychiatric ward rounds

DEAR SIRS

Dr McBride (*Bulletin*, February 1988) addresses the format and use of ward rounds.

I would propose that, just as there is no single formulation for a patient, there is no ideal ward round which is applicable to all situations.

General psychiatry is very different to some of the sub-specialities. In child psychiatry one ward round a week is adequate; however the presentation of a new case may take up to an hour with various disciplines contributing. On a general ward where there is a rapid through-put I feel two rounds a week are preferable, perhaps with one being a mini-round conducted by the SR.

I feel it is wrong to divorce teaching from the ward round. All the disciplines have much to learn from each other; thus the consultant is not always the teacher, nor the registrar always the pupil. Academic psychiatry is better understood and remembered when learned in a clinical setting. If patients are to be spared the trauma of being interviewed in the round then they should be seen both before (to ascertain mental state) and after (to inform). The cohesiveness of any team will be eroded if any member ignores the team plan; a doctor is more likely to be guilty of this if he fails to assess the patient adequately before or during the round.

The timing of a round will depend on local factors. Although the morning is busy, a round then permits investigations, phone calls and letters to be completed by the end of the day.

There is no 'correct' format for all rounds but Dr McBride's article has prompted many of us to criticise them for the first time.

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The College and South Africa

DEAR SIRS

When Christian Barnard pioneered the first heart transplant, Malcolm Muggeridge, during a televised debate, repeatedly asked "Why South Africa?". It might now be appropriate to ask "Why the Royal College of Psychiatrists?", as the British Psychological Society and the London Colleges of Physicians and Surgeons, among others, have not been similarly prompted to encourage, in effect, an academic boycott of that country. Its value in promoting stabilisation and the over-due abolition of apartheid is debateable, to say the least. According to Professor Simpson (*Bulletin*, April 1988) Fellows continue to make well-funded visits to give presentations "usually irrelevant to our real professional problems". What is the motive behind this posture of the College?

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Part-time training in psychiatry

DEAR SIRS

Some of my colleagues and I are becoming increasingly concerned about the difficulties experienced by those doctors (usually but not only women with children) who want to train in psychiatry on a part-time