the approach towards German psychiatry should certainly be a most critical one.

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A full list of references is available on request from Dr Förstl.

DEAR SIRS
I thank Dr Förstl *et al* for their interesting and educational reply to my letter.

I wonder whether a syndrome has been described which might be applied to a psychiatrist who mistakenly identifies two almost identical syndromes? If so, perhaps *this* is what I am suffering from.

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A register of Munchausen cases?

DEAR SIRS
Davey (*Psychiatric Bulletin*, March 1991, **15**, 167) adds his voice to those calling for a register of Munchausen cases. An interesting natural experiment with such a register took place some years ago when a knowledgeable patient with feigned Zollinger-Ellison syndrome frequented many hospitals demanding Omperazole, a drug under investigation with the details of all receiving patients held on a central register (Daly *et al*, 1989). This register enabled the patient's travels to be recorded in some detail and the authors comment that he would not have been identified without a register. However, in their letter they suggest that the diagnosis of factitious illness was made before consulting the register. Further evidence that a 'black-list' is not essential for diagnosis is provided by the fact that this same man had already made an inconspicuous entry into the medical literature (Lovestone, 1987).

The arguments against a register are strong. We should be cautious at any such breach of confidentiality and the legal complications may be serious. I wonder at the effect of having a list of patients with feigned physical illness on the practice of liaison psychiatry. It might contribute to increasing the "is it psychological or organic" type of referral – an often unhelpful dichotomy.

Although Davey calls for a register, he fails to actually state why. Making a diagnosis of Munchausen syndrome is in itself not particularly helpful to the patient as we do not know how to treat this condition. Protecting the patient from iatrogenic harm is important, but we can trust our colleagues only to perform invasive procedures when a diagnosis of Munchausen syndrome is not yet being considered – and hence a register not consulted. Jones (1988), quoted by Davey, is more explicit. The benefits of a register are economic and to be calculated in terms of cost benefit analysis. This is a poor reason – even in the new NHS doctors must strive to be more than accountants.

I suspect the reason underlying calls for a register lie within the physician and not the patient. Being 'caught out' or 'conned' is an unpleasant experience and it is understandable that doctors should wish to avoid it. In the spirit of Asher I would propose a fourth variant of Munchausen syndrome 'Homo connus phobia et registerphilia' – a disorder of doctors.

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The use of carpets in geriatric and psycho-geriatric wards

DEAR SIRS
It is to be hoped that the eloquent and passionate protestations of Dr David Jolley (*Psychiatric Bulletin*, March 1991, **15**, 168–169) do not obscure the issues relating to the use of carpets in geriatric and psycho-geriatric hospital wards. He is partially right. Anyone who has worked in institutions caring for elderly people knows that offensive smells are not uncommon. While carpets are often associated with these smells, the smells are not confined to wards

where floors are carpeted. Previous correspondents are right in asserting that a proper programme of incontinence management will reduce the incidence of incontinent accidents and consequent smells. However, I have learnt that such accidents will occur from time to time despite the most effective programmes of care. Nevertheless, I have chosen to champion the use of carpets in geriatric and psycho-geriatric wards for a number of reasons.

(a) Vinyl flooring is objectionable acoustically and aesthetically, and adversely affects the milieu of the ward. This is likely to affect the behaviour of patient and staff.

(b) Some types of vinyl flooring adversely impair the gait of elderly people whereas carpet does not (Willmott, 1986).

(c) Vinyl flooring, when wet, increases the risk of falls and their personal and financial costs. Falls which occur in carpeted areas are probably less destructive than those which occur on vinyl floors.

With a local carpet manufacturer, I have developed a cleaning process which eliminates smells emanating from biological products deposited in carpets in psycho-geriatric wards. As yet, this is an assertion since we have been unable to persuade the carpet industry to develop a research programme to test the efficiency of cleaning methods on their products. It seems ridiculous that a carpet and/or cleaning system that eliminates smells has not yet been developed. Everyone, including Dr Jolley, would probably agree that the most appropriate floor covering should be carpet if it were possible to solve the problem of offensive smells. Our proper concern should therefore be how best to develop an acceptable method of carpeting and cleaning such areas, rather than accepting vinyl, very much a second best solution, for wards which house patients who are already treated as second best.

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Reference

WILLMOTT, M. (1986) The effect of a vinyl floor surface and a carpeted floor surface upon walking in elderly hospital inpatients. *Age and Ageing*, **15**, no. 2.

Junior doctors' hours

DEAR SIRS

Current attempts to reduce excessive hours for us junior doctors will never succeed, as evidenced by the recent unsatisfactory and predictably deferred 'agreement' that has been reached. The simple reason is that the thrust of our campaign is misplaced. What is needed (and note the example of our Irish colleagues) is a demand that we be paid at least equal rates for overtime hours instead of the archaic one-third. Only then will the financial motivations which maintain these excessive hours be removed. Our successors will not thank us for our myopia, even if it is overtime-induced.

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