further in-patient treatment for a period of one month should be obligatory.

8. University Psychiatric Departments must now be integrated into the existing pattern and must taken responsibility for District care and have the kind of administrative autonomy which is denied to other Mental Health Services. They should also be allowed to admit patients from other districts or regions thus restoring their status and power.

Supporters of the present Law feel that there is little wrong with it but that it has sometimes been wrongly interpreted and often wrongly applied. Some changes would seem to be inevitable, but whatever the outcome of the present deliberations, it seems important that the Italians should not go back in time and lose the impetus which has been created and which has put Italy once again in the forefront of the field of psychiatric reform.

Trainees' Forum

Contributions are welcome from trainees on any aspects of their training

Psychiatric Training in America: Two Initial Impressions

I: Janet Lawrence, Harvard University, Boston

The last year has been a fascinating one for me as a British medical graduate in many ways, constituting, as it did, my introduction to both American culture and a career in psychiatry. I have just completed my first year of a three-year psychiatric training programme (residency) at Harvard Medical School, roughly equivalent to a combined SHO and registrar training in Britain.

As I look back on the year, many of my experiences must have been comparable with those of British trainees at my level. The bulk of the first year's work was on a small acute psychiatric in-patient unit in the general hospital where my residency is based. Throughout the year, I also saw emergency-ward patients and gradually increased my out-patient load. Much of my time was also spent in didactic sessions and receiving four to five hours per week individual supervision, mainly on the patients under my care, from staff psychiatrists and psychologists.

In spite of the many similarities, there were sufficient differences that I was always reminded of working in a different cultural setting. The differences that were immediately apparent to me were those which I shall call the 'American scene'. Another large group of my impressions of the year might be included under 'economic factors'.

My first realization of medical cultural differences came just after the initial bewilderment of the first few weeks had worn off. We had watched a senior staff member interviewing a patient who had throughout the interview wise-cracked at the psychiatrist, answered the psychiatrist's questions with questions about how the doctor would feel in the circumstances and had, to my British ears, sounded abrasive. My comment that he appeared to be hostile to the interviewer was met with much amusement. Apparently, American patients did not show the same kind of respectful, submissive stance towards their doctors as did British patients unless, of course, they really were hostile. Indeed, most British patients seen by American psychiatrists might seem pathologically compliant. This lack of formality was often also evident in working relationships, both in the considerable day-to-day communication between different levels in the hierarchy and in the encouragement of residents to provide feedback on the standard of teaching, through written assessments.

Other cultural differences became evident in the nature of my clinical practice. Recreational drug use, or at least past extensive experimentation, appeared to be ubiquitous among patients aged under 40 whom I saw last year. This was apparently not limited to the psychiatric population; a survey publicized by the media during this time found that 90 per cent of New York school children had experimented with drugs and a very high proportion was still using them.

Another difference emerged in the frequency of rape, probably both in terms of its incidence and its reporting compared to Britain, where during a six-month stint in a London emergency ward I did not see a single case. It was not uncommon to see two or three rape victims within a single night on call in Boston, admittedly in a hospital well known for its rape-counselling programme. This programme trained psychiatry residents, psychology and social work interns as counsellors in rape crisis they saw the victim on arrival in the emergency ward, prior to gynaecological examination. This provided an opportunity for the victim to ventilate feelings of anger, shame and often guilt, to be

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informed about some of the psychological sequelae of such a stressful event, and to be offered 12 further sessions of counselling.

Rape has been considerably politicized by the women's liberation movement and is seen as an act of aggression directed against women, rather than of sexuality. In contrast, I note that the reading list issued by the Royal College of Psychiatrists mentions only two references (both American) on rape and both under the heading of sexual perversion, and with no mention under women's issues or forensic psychiatry. Possibly as a result of the increased reporting following this politicization, many of the rape victims seen, while fitting the State of Massachusetts' definition of rape—sexual intercourse performed without consent or with use of threat or force—produced a struggle for me as a therapist because the issue of responsibility often seemed questionable. This struggle abated by the end of the year as I began to realize that the intra-psychic issues were often similar, or equally important, for both the woman raped by an intruder while asleep at home and the woman who had shown poor judgement in a relationship with a male acquaintance.

Another cultural phenomenon I have noted is the different position which psychology and psychiatry occupy in American society compared to that in Britain. In all likelihood, this is more marked in a city such as Boston with its high concentration of psychiatrists, than in more remote areas. This is most manifest in two ways: the large numbers of pop psychology books which make the bestseller lists, and the remarkable numbers of middle-class people without serious psychopathology who have been in therapy. Of my current out-patient load, perhaps a quarter to one-third are people who are unhappy with their lives and who, while they may benefit from therapy, would not dream of the luxury of seeking it were they living in Britain.

This brings me to the other major difference between the States and Britain, that of economic factors. One reason that so many relatively healthy people can and do see a therapist is that they can afford to, although often not without a degree of financial sacrifice. In my case, the most disturbing change was that from working within the NHS to working in a system where the care received was often largely determined by the patient's financial status. Nowhere was this difference more manifest than in the emergency ward, when attempting to hospitalize seriously-ill patients. The luckiest were those with comprehensive health insurance, allowing up to 40 days per annum in a private in-patient unit or unlimited coverage in a general hospital. It was an education to have to consider such factors as whether the patient's relatives could provide the sizeable deposit necessary before hospitalization at the private facilities, outside of office hours when insurance policies could not be checked. These factors and the shortage of psychiatric beds in Boston made hospitalization of the patient a long, often agonizing, procedure. Those patients with state insurance such as Medicaid or Medicare could be accepted by general hospitals, but these usually had waiting lists, often necessitating admission to the understaffed and underfinanced state hospital system. The latter was the only option for many of the chronically mentally ill and others with no form of health insurance.

Financial concerns affect the care the patients receive in other ways. One interesting and increasing effect of the influence of third party payers on patient care is that it is difficult to prove the efficacy of much psychiatric treatment, calling into question the degree to which insurance companies will reimburse. This is so especially when the more expensive care delivered by psychiatrists cannot be demonstrated to be more effective than that delivered by non-medical professionals.

This has caused considerable consternation in the psychiatric community, and was a topic of prolonged discussion in my department in which the emphasis has always been on psychoanalytic psychotherapy. The restriction of third party payment and the effects on private practice of the recession have resulted in an increased emphasis on means other than individual therapy of treating patients and increased concern about the length of stay in the in-patient unit. These and other financial stringencies have led to a restructuring of subsequent first years of the residency programme and will, I fear, have possible future effects on the service requirements of the training. It will be unfortunate if this results in a reduction of the enormous amount of group and individual teaching which I felt was of so much benefit to my training in the last year.

II: Peter A. Bick, Upstate Medical Center, New York

It was quite an anticlimax to land in New York. After passing the right exams, getting a job and, most important of all, proving to the authorities that I was not a Communist(!), I had arrived as a new immigrant. Keen to start work, I signed on the payroll eight hours after arriving in Syracuse. Noting the location of the nuclear fallout shelter, I began my tour of duty.

My initial assignment as a new resident in psychiatry was as Primary Liaison Consultant. Translated into English, this meant that I dealt with the previous evening's suicide attempts. Variation was to be found in method. My first case, for example, was a man who had taken an overdose of Phencyclidine and subsequently shot himself in the head with an airgun.

Disposition is an important word in American medicine. In taking a history one is required to enquire into monetary matters prior to asking name and age. There are three categories of patient care available. One is for Veterans who

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have their own free facility, a second is for the rich or heavily insured, and lastly, there is a free state facility for the poor. One is quick to observe a bizarre trichotomy of psychiatric treatment in the three groups: drugs, psychotherapy and drugs respectively. Subgroups do, of course, exist. For example, the treatment of a middle-class individual often involves handing the unfortunate a copy of the Yellow Pages. Directions are given to choose therapy administered by someone whose name ends in Ph.D. as this is more economical.

The place of electronconvulsive therapy is a wonderful indictment of the American system. The indications for ECT are not governed by such mundane matters as the degree of depression or resistance to therapy. Surprisingly, dollars influence the prescription of ECT—lots of them. ECT is a money-winning treatment of the physicians which enables them to charge exorbitantly. Pressing buttons instead of fussing with psychotherapy is indeed a 'get rich quick' method.

The Veterans Administration system of care was my second assignment. Veterans are entitled to free treatment in these hospitals. Motivated by a belief that the government owes them something, Veterans hold out their hands for more. The gruel administered comes with an expediency reminiscent of a Dickensian workhouse. Memories of Vietnam still dominate the psychiatric scene. These men are often poor, usually forgotten and always undervalued.

The doctor-nurse relationship in American hospitals was another source of culture shock. As a result of diffusion of boundaries, the status of being a doctor has been eroded in American psychiatry. The 'team' is a key concept, with everyone having their say. Ward rounds do not exist except in the fond memory of ageing consultants. They have been replaced by the team meeting, a kind of therapeutic community with no chairman. Staff members are encouraged to ventilate at tangents and knights-move decisions are made. Indeed, to avoid being considered supercilious, I soon learned to leave my stethoscope at home.

Legal psychiatry in the States is another bone of contention. Translating from double-speak, this term largely refers to the avoidance of malpractice suits. The American public is obsessed with the notion that patients' rights must not be violated. This noble ideal presupposes that psychiatrists strive to lobectomize people in their sleep! This overkill attitude decapitates the thrust of progressive care. Psychiatrists are afraid of being sued for giving the wrong treatment, wrong being synonymous with unorthodox. The issue of enforced medication is a case in point. Doctors have been successfully sued for giving such treatment to patients. Conversely, there is a 'right to treatment' statute that has been used to sue doctors who failed to enforce medication when this was indicated. Because of such issues, a doctor is impelled to indulge in a certain amount of bureaucratic coprophagy in the course of administering treatments. The ramifications of American legal medicine are exemplified by the absence of a service fee for lawyers specializing in malpractice. They simply charge on the handsome spoil of the settlement figure.

With three months of American psychiatry now behind me, I feel suspicious that my own psychopathology is being mobilized. With prophylaxis costing one hundred dollars an hour, I shall just continue to take the tablets!

News Items

Current UK Alcohol Research Projects

A register of current research into alcohol use, misuse and effects is being compiled by the Alcohol Research Group at Edinburgh University. For further information and forms please contact Jane Pattison, Alcohol Research Group, University Department of Psychiatry, Royal Edinburgh Hospital, Morningside Park, Edinburgh EH10 5HF.

Journal of Psychiatric Research

Professor Merton Sandler (University of London) and Dr Joseph J. Schildkraut (Harvard Medical School) have recently taken over the role of joint Editors-in-Chief of the *Journal of Psychiatric Research*—they succeed the founding editor. Dr Seymour S. Kety. The journal has been remodelled and now has a distinguished international Editorial Board to supplement its previously all-American one. It is hoped that the journal's high standard may be maintained and that the present publication lag can be drastically reduced. Submissions are now invited and should be addressed to Professor Merton Sandler, Bernhard Baron Memorial Research Laboratories, Queen Charlotte's Maternity Hospital, Goldhawk Road, London W6 0XG.

Dr Philip H. Connell

The Home Secretary has appointed Dr Philip H. Connell to be Chairman of the Advisory Council on the Misuse of Drugs. He succeeds Sir Robert Bradlaw who retired this year. Dr Connell is the Director of the Drug Dependence Clinical Research and Treatment Unit at the Maudsley Hospital, London and Chairman of the Institute for the Study of Drug Dependence.

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