guidelines for community services to be in place before discharge and recent well publicised failures in community care, consultants are understandably taking fewer risks and are delaying discharge. Unfortunately this has had a 'knock on effect' for junior doctors assessing patients in accident and emergency departments. Often one is aware that there are no vacant beds on the psychiatry wards and admission could only be effected by using 'leave beds' or trying to use beds in other hospitals. Faced with this situation, the threshold for admission rises and increasing risks are taken. Thus the responsibility for taking risky decisions has been shifted from a consultant psychiatrist on the ward to a junior doctor in casualty.

Surely this trend is not the way forward.

FRANCES FOSTER, *Fazakerley Hospital, Lower Lane, Liverpool*

Job-sharing a consultant post

Sir: As a consultant psychiatrist imminently expecting the arrival of a fourth baby, I found the article by Black & Callender on job-sharing a consultant post (*Psychiatric Bulletin*, January 1994, **18**, 47–48) very helpful and encouraging.

In 1991 the Department of Health became the first government department to join Opportunity 2000 in an effort to increase women's participation in the NHS. One of the stated goals was to increase the percentage of women consultants to 20 by the end of this year. Sadly there seems to be no prospect of achieving this and I believe that the prospects will remain bleak while colleagues continue to view new ways of working such as job-sharing with a high index of suspicion.

The Royal College of Psychiatrists under the presidency of Dr Fiona Caldicott has been extremely encouraging in this area, and I understand that a College Adviser on flexible training and flexible working is shortly to be appointed. However unless the College exerts strong leadership and continues to send out regular signals on this topic, it is my impression that there will continue to be subtle opposition to job-sharing and fair part-time work with all the resultant wastage of skills and resources that this implies.

ANNE CREMONA, *Wexham Park Hospital, Slough, Berkshire*

The dangers of the 'internal market'

Sir: In parallel with the development of the NHS purchaser/provider split, an alternative 'internal market' has emerged in many hospitals – the phenomenon of the hospital lobby market stall – usually selling such health-care necessities as cut-glassware, handbags, compact discs, jewellery and training shoes. Informal questioning reveals that these stalls 'generate income' for the hospital in the form of site fees paid by the stallholder.

Recently, a stall was set up in the main lobby of this hospital, selling 'discount cutlery'. Closer inspection revealed an assortment of carving knives and breadknives openly laid out for inspection. Three wards, accommodating up to 75 acutely ill psychiatric patients, are situated in the same building. On that day, as is usually the case, the wards contained a number of patients at risk of self-harm and several with a history of dangerousness to others and risk of further dangerousness.

Alan Lillywhite (*Psychiatric Bulletin*, February 1994, **18**, 113) recently highlighted the assault potential of sharp metal letter-openers offered by drug company representatives. This example focuses attention on the dangers of giving planning responsibility for such income generation schemes to staff who have neither the clinical training, experience nor common sense to make decisions which ultimately affect the safety of staff, visitors and patients. The risks of bypassing clinical input are clear when designing such ventures.

ROBIN IRELAND, *Newtown Branch, Worcester Royal Infirmary, Worcester*

Health care in Kerala

Sir: We read with interest the foreign report by R. and L. Hackett (*Psychiatric Bulletin*, 1993, **17**, 752–754) which regrettably fails to give a comprehensive picture and is riddled with dangerous generalisations and distortion of facts.

Kerala is one of the most densely populated, culturally mixed and politically unusual states in the world. About the size of Switzerland, it has a population of 30 million people, 60% are Hindus, 20% each Muslims and Christians. Midway along the spice route between Rome and China, Kerala thrived as an international meeting place from the 1st century AD so becoming the first destination in India for Christians, Jews and Muslims, whose descendants have added a cosmopolitan flavour to this enlightened Hindu state.

However, Kerala is now known for different reasons. In 1957 it voted a Communist government to power, the first in history. More recently, its success has received wide attention, "it is a poor state in a poor country which manages to keep its people alive longer and educates them better than any of the world's lower income countries" Baird (1993). Radical land reforms, female literacy and voluntary family planning enabled Kerala's people to achieve a quality of life

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comparable with many Western countries. Health and economic indices which give insight into its present status are listed below.

(a) A literacy rate of 91%, compared with 96% in USA.
(b) Over 90% of people in Kerala own the land on which their home stands. "There are more homeless in the streets of London than in Trivandrum (Kerala's capital city)" (Baird, 1993).
(c) Eighty-five per cent of girls stay at school until age 14 and more than 30% of government jobs are held by women.
(d) Kerala's crude birth rate and infant mortality rate compares favourably with European countries (Black, 1993).
(e) Health awareness and standards are high and most families have access to primary care facilities within walking distance.

Pockets of privation exist in Kerala, as in any country. But the "selective abstraction and over generalisation" which characterise the report makes one wonder whether the authors were interested in research or in sensationalism typical of the "butterfly catching transcultural psychiatrists".

BAIRD, V. (1993) Paradox in paradise; Kerala, India's radical success. *New Internationalist*, **241**, 1–28.
BLACK, J.A. (1993) The population Doomsday forecast: lessons from Kerala. *Journal of the Royal Society of Medicine*, **86**, 704–706.

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ALBERT MICHAEL, *St Bartholomews' Hospital, London EC1A 7BE*
(Both formerly lecturers in psychiatry, Medical College, Trichur, University of Calicut, Kerala)

Sir: I read the foreign report by the Hacketts (*Psychiatric Bulletin*, 1993, **17**, 752–754) with a sense of *jamais vu*. I have practised psychiatry in a university teaching hospital in Kozhikode (formerly known as Calicut). I could not recognise the place they described.

Kerala is one of the most progressive states in India. It has been hailed as a model for social and economic development for the so-called third world and the poor European nations (Baird, 1993). People in Kerala live longer and the quality of life is comparable with many Western countries (Jeffrey, 1992). Ninety per cent of Kerala's villages have a fair price shop within two kilometres and two thirds of the state's subsidised basic foods go to the poorest 30% (Frankey & Chasin, 1991).

Free primary health care facilities are available within walking distance for the majority of the population (Black, 1993). Of the 3000 psychiatrists in India (population=800 million), about 800 are practising in Kerala (population=30 million). I appreciate that child psychiatry has not achieved the status of a sub-speciality but many psychiatrists take special interest in the psychological care of children. I always believed that the paediatricians and neonatologists in Kerala are doing a good job. An infant mortality rate of 27 per 1000 bears witness to the high standards of paediatric care and nutrition (Black, 1993). The grim picture of a third world country, ridden with dirt, disease and poverty as painted by the Hacketts, is totally inaccurate.

They make a sweeping statement that children of Kerala have to struggle with material deprivation, oppressive regimes of formidable elders and harsh religious indoctrination: they compare them with the "liberally reared, centres of attention children" in Britain. I found this amusing. Having worked in the child psychiatric departments of London and Dublin, I have come across many deprived and neglected children. It will be unpardonable for me to generalise from this experience, like the Hacketts have done. They remind me of the proverbial blind men who ventured to 'see' the elephant: the authors seem to have fumbled upon a patch of pyoderma and did not care to appreciate the magnificent trunk and tusks.

BAIRD, V (1993) Paradox in paradise; Kerala, India's radical success. *New Internationalist*, **241**, 1–28.
BLACK, J.A. (1993) The population Doomsday forecast: lessons from Kerala. *Journal of the Royal Society of Medicine*, **86**, 704–706.
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K.A.H. MIRZA, *The Maudsley Hospital, Denmark Hill, London SE5 8AZ*

Sir: Our description of one of the areas where we conducted our epidemiological study into neuropsychiatric disorders in children seems to have touched a nerve. Although Babu & Michael and Mirza berate our account for generalising, it is they who have extrapolated our comments beyond the area from which we randomly selected our 1400 subjects. In doing this they have uncritically quoted state-wide statistics from the colourful magazine *New Internationalist*. These conceal the wide economic diversity of the state. Indeed Calicut District is probably not the poorest in Kerala. Have they ever rolled up their sleeves and conducted a large epidemiological study?

Our differing perceptions may also stem from the fact that they were medical college psychiatrists while we were doing door to door research in the community. Our experience was that many young psychiatrists have seen little of

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