CORRESPONDENCE

EXAMINATION RESULTS OF FOREIGN PSYCHIATRISTS

DEAR SIR,

It is regrettable that Dr. Mahapatra should have plunged into this subject (*News and Notes*, January) without adequately considering the evidence of cross-cultural psychology. It is abundantly clear (e.g. Vernon, 1969) that subjects from non-technological cultures have particular difficulty with problems involving spatial perception and manipulation; and there is evidence (e.g. Bhatia, 1955; Young, 1970) that this varies with social and educational levels within these cultures.

On the basis of this evidence, it might have been hypothesized that the foreign students would have the greatest difficulty in the most 'spatially-dependent' subjects like neurology, the least in verbal-conceptual subjects like psychology and social science, and possibly intermediate difficulty in genetics etc. (At the anecdotal level, I well recall an African D.P.M. student saying to me, 'of course I found the anatomy hardest: I can't think how you chaps just seem to be able to *imagine* the Circle of Willis.')

In fact, the examination results quoted by Dr. Mahapatra do not support this hypothesis any more than they do his own (that the foreign students would have greatest difficulty with the language-based subjects). It is therefore possible that both hypotheses are true, and that their effects cancel each other; or that neither is true, and that the reasons for the foreign students' uniformly poorer results must be sought elsewhere.

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VERNON, P. (1969) *Intelligence and Cultural Environment*. London: Methuen.

YOUNG, H. B. (1970) Socio-economic factors in child development. *Bibl. 'Nutr. Diet.'*, 14, 43–63.

DEAR SIR,

As a foreign psychiatrist I agree entirely with Dr. Mahapatra's analysis of the reason of discrepancy in success rate between foreign and British doctors. But in my own experience I could not pass the essay papers before improving my English grammar, dictation and composition which is not relevant to my work at home.

I wish the examiners put their scores for knowledge rather than language technicalities.

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NEEDS OF THE MENTALLY HANDICAPPED

DEAR SIR,

I was amazed that Dr. Day (*News and Notes*, January 1975) should consider that the medical component of mental handicap is insufficient to justify a specialty. The approach of shared responsibility in a care situation will discourage most young doctors; on the other hand the exciting possibilities of harnessing modern scientific developments to the appalling problems of mental handicap will attract able young applicants to the specialty.

The particular medical aspects should fall under the following headings:

(1) Aetiological diagnosis. This is important, for it is only as aetiological diagnosis becomes established and extended that preventive measures are possible. The American President's Committee on Mental Retardation for 1972 stated it was their aim to halve the incidence of mental retardation in the U.S.A. by the end of the century. This figure may be unduly high, but there can be no doubt that there is considerable scope for preventive measures within the framework of present knowledge.

(2) The treatment and management of disturbed behaviour in the mentally handicapped. Much of this is doubtless due to poor training, but much is of biological origin although modified by handling and management of the patient. The change in psychiatric illness as one descends the intellectual scale has been described by Reid (1972). Most would agree that formal psychiatric diagnosis is rarely possible below an IQ of 50, yet the problem of classification and treatment of biologically determined disturbed behaviour in the severely subnormal remains an important clinical problem.

(3) The care of those patients severely physically as well as mentally handicapped.

(4) Study of the neurological basis of learning and developmental disorders. This is a subject yet in its infancy, but at a very elementary level it is surprising how often a hemiplegic child will be attending 'school' without the teacher being aware there is an hemianopia.

If we as doctors concern ourselves with the medical and psychiatric aspects of mental handicap there is a very worthwhile job to be done, and it may well be that psychiatry as a whole will benefit, a possibility discussed by Penrose (1966) and Winokur (1974).

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Winokur, B. (1974) Subnormality and its relation to psychiatry. *Lancet, ii*, 270–3.

Dear Sir,

I noticed Dr. T. Lawlor's letter on page 10 of the March issue of *News and Notes*. With regard to the last paragraph, Dr. K. Day was invited to work as a consultant with the Hospital Advisory Service because, in the opinion of those who knew him, he was one of the most able consultants in the field of mental handicap. Since working for the Hospital Advisory Service he has also been granted a Churchill Travelling Fellowship, and has seen services to the mentally handicapped in other countries.

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[*This correspondence is now closed*—Eds.]

WOMEN IN PSYCHIATRY

Dear Sir,

Dr. Elizabeth Harris is certainly not the only person to be totally dissatisfied by correspondence with the DHSS. The reply from Dr. David Owen strikes me as typical of the response one gets: no reply to specific points, if possible a mass of incomplete and irrelevant statistics. Since there has been a virtual moratorium on the appointment of medical assistants for the past five years, it is meaningless to compare the numbers with those of consultants unless the figures for whole- and part-timers in both grades are broken down into 5-year cohorts by age or by length of service in the grade, or preferably by both parameters. To get a true picture, it would also be necessary to know how many women doctors had been forced to take clinical assistant posts for lack of suitable posts in the consultant and medical assistant grades.

It is not at all clear either from Dr. Owen's letter or from the proposed consultant contract who is to be the final arbiter in deciding when personal circumstances make it impossible for a doctor to carry out the duties of a full appointment—or indeed what is meant by personal circumstances. This vagueness is particularly ominous when taken in conjunction with the clause of the contract which states specifically that where the amount of work is excessive for the number of sessions the appointee will be required to cope with the workload *until such time as a further post is created* (which will presumably be when the millennium comes or at the Greek kalends, whichever is the later). Since, as most of us are already aware, workload frequently has only a tenuous relation to sessions worked, I cannot see that it is anyone's business but one's own if one elects to take a lower salary and work fewer sessions. What one chooses to do in one's own time—providing it is not criminal—is strictly one's own affair, whether it is housekeeping, breeding pedigree goats, practising Yoga, indulging in good works, being an M.P., or even (horror of horrors) having a private practice. No other profession would tolerate such interference. Once we accept the principle of a bureaucratic restriction on what we may do in our own time we open the door to a whole series of such restrictions: the present proposals seek merely to restrain us from augmenting our salaries by practising our particular skills in circumstances of our own choosing (incidentally, no-one seems to have considered the possibility that some people might wish to use free sessions for voluntary counselling activities: would this be permitted or not?), but in the present political climate it seems likely that the next move might be restrictions on journalistic activities and particularly access to the public media. This probably sounds alarmist, but freedom is as fragile as the modern motor-car and it is the first small erosion that opens the way to widespread and rapid destruction.

Incidentally, has anyone worked out the implications for psychiatrists of what I gather to be the new rules regarding superannuation? i.e. that after 1980 persons earning over £5,000 p.a. (which, at present rates of inflation, should include everyone from housemen upwards) will not be allowed to withdraw their superannuation on leaving the NHS early (except premature retirement on account of illness), but their contributions will be frozen and a