TABLE I
Assessment of clinical posts by trainees

	Poor		*Adequate*		*Good*		*Excellent*	
	n	%	n	%	n	%	n	%
Overall value of post	2	2.4	4	5.8	24	34.7	39	56.5
Consultant supervision	3	4.3	15	21.7	28	30.5	23	33.3
Quality of patient care								
1988[1]	2	2.4	12	17.3	31	44.9	24	34.7
1977[2]		2.6		21.9		45.8		29.7
1974[3]		4.6		19.3		47		28.4
	Strongly							
Participation in research	*encouraged*		*Encouraged*		*Ignored*		*Discouraged*	
1988	6	8.7	36	52.2	26	33.7	1	1.4
1977			27.1			71.4		1.6
1974			36			64		0

1. Current study.
2. Creed & Murray, 1981.
3. Jeffreys & Murray, 1976.

Psychiatric training at the Maudsley Hospital

DEAR SIRS

The above table was omitted from the published version of our paper 'Psychiatric Training at the Maudsley Hospital: A Survey of Junior Psychiatrists' (*Psychiatric Bulletin*, May 1990, **14**, 289–292). The table displays the results of a survey of Maudsley Hospital SHOs and registrars and compares results with two previous surveys (Creed & Murray, 1981; Jeffreys & Murray, 1976).

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JEFFREYS, P. M. & MURRAY, R. M. (1976) Trainees' assessment of vocational training in psychiatry: a pilot study at the Maudsley Hospital. *Medical Education*, **10**, 52–55.

Patients' participation in examinations

DEAR SIRS

In response to the letter by Dr Lynch (*Psychiatric Bulletin*, May 1990, **14**, 308) concerning the adverse effects on the mental state of patients participating in examinations, I can only write to agree. I was recently involved as organiser of the MRCPsych Part I examinations in Newcastle, and noted a number of responses among our patients. One group seemed positively to enjoy the experience, two patients being so pleased to be of help that they donated their £8 fee to the hospital cancer research fund. A small group, however, were quite badly affected; one man with schizo-affective disorder became markedly anxious and rather paranoid, a depressed lady (after being very enthusiastic) somatised her distress and withdrew with back pain, while another obsessional man broke down somewhat after interview and began to experience depressive and suicidal feelings we had previously successfully controlled.

I found that the best methods for dealing with the distress which largely resulted from anticipatory anxiety, the tense atmosphere of examinations and boredom, were the well tried diversionary activity provided by nurses in attendance, a portable television, and a steady supply of cigarettes.

Another interesting point was the effect on the mental state of those organising and running the exam, which seemed to veer between depressive despondency ("none of the patients will turn up"), manic denial ("who cares!"), and a particularly nasty obsessionality, evoked when trying to keep the exams running smoothly.

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The double negatives and the Mental Health Review Tribunal

DEAR SIRS

As lay and medical members of the Mental Health Review Tribunal we are interested in the letter from

Drs Shiwach and Rutherford (*Psychiatric Bulletin*, May 1990, **14**, 311–312) on this subject.

The construction of sentences using the double negative such as "the Tribunal is not satisfied that the patient is not now suffering from mental disorder" is a form of litotes, which, according to the second edition of *Fowler's Modern English Usage*, is the same as or a variety of meiosis. We concede that one purpose of rhetorical litotes is to impress by moderation but in Tribunal reports and indeed in legal reports in general such statements, far from being "strong positives" or colloquiallisms like "He didn't say nothing", are used evasively and deliberately to qualify what one is saying when one cannot really say it positively. Hence, for example, although the Tribunal is not satisfied that the patient is suffering from mental disorder, it is not satisfied that the patient is not suffering from such a disorder.

We concede too that patients themselves may have difficulty in understanding the Tribunal's double negatives but the patients are surrounded by highly intelligent carers who could easily explain these sentences to them.

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General management

DEAR SIRS

I read with some apprehension and disquiet the letter from Elaine Murphy (*Psychiatric Bulletin*, April 1990, **14**, 237), regarding general management.

I feel that she continues to miss the inherent difficulty in general management in stating that while the service is provided by a *team* it should be managed by *one* person, this person being accountable to *one* other. She, therefore, infers that the team as a whole have faith and confidence in this one person, which, in my own experience, is often not the case and while stating that she found it perfectly acceptable to be accountable to a non-doctor, she did not state in which areas she wishes to be accountable. I note that she, herself, has taken the route of becoming a District General Manager, thus no doubt seeing herself as "managing" her colleagues. However desirable this may be to the smooth running of the multidisciplinary team, in many parts of the country District and Unit General Managers have no medical training and this leads to obvious conflict within the multidisciplinary team.

I firmly believe that psychiatrists remain in the "business" of managing the care of their patients, many of whom are the most vulnerable in society. Conflict caused within teams by lack of confidence and belief in the one person, whom Dr Murphy would hold accountable, only damages the level of care to the patients whom we should serve. Unlike Dr Murphy, I believe that members in the Health Service are right to regard the onset of general management with a healthy cynicism and suspicion. The threat to the co-ordinated wide-ranging care which we currently provide posed by recent Government legislation is only enhanced by such zealot-like views as those expressed by Dr Murphy. General management does have a lot to offer in terms of constant review of our aims and objectives but should not be regarded as an ideal and totally desirable option to other current management structures.

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DEAR SIRS

Dr Palin is quite right that a manager who is unable to inspire the confidence of the team members who are accountable to him or her is useless. It is crucial that whether a manager is a clinician or administrator that people are able to respect his/her skills. I also agree with him that there are plenty of bad managers and I should add there are as many bad nurse and doctor managers as there are bad administrator managers. But the fact of the existence of bad managers does not undermine the fundamental importance of having individuals accountable for achieving the overall objectives of a team. Conflicts between professionals will arise in any healthy team and there needs to be an effective means of resolving them. Separate professional lines of management for individuals in a team militate against effective decision making.

Management obviously means very different things to Dr Palin when referring to the activities of a District General Manager (para. 2) compared with what he does when he "manages" the care of patients (para. 3) i.e. work with a team of committed professionals to ensure the best decisions for care and treatment are made within the constraints of the staff and services available to him and the wishes and compliance of the patient. Maybe the same skills are used in both District and patient types of management, when practised effectively.

I may be a zealot for good management but much more of one for good coordinated multidisciplinary care. The two are entirely compatible.

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