I have been surprised at the common ground between management development and psychiatry: transactional analysis, gestalt, listening skills, positive belief cycles. Although my knowledge of this common ground is sketchy, my postgraduate psychiatric training has already re-kindled management skills that six years of medical school and house jobs conspired to obliterate. In addition, much of the course material is directly applicable to my clinical work.

I am not concerned about what is 'required of me' as a manager but rather what I require of my organisation. I also realise that I have had a range of effective management skills for years, without being aware of them, and that I can continue to develop them in the light of future needs. All of my colleagues in training have extensive management ability, but rarely acknowledge this fact themselves. Management training can help us to improve existing talents, and it is up to us to critically appraise, and choose, the courses which suit our needs.

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Management training

DEAR SIRS

Dr Jadresic's paper on management training (*Psychiatric Bulletin*, February 1992, **16**, 86–87) serves as an important reminder of controversy surrounding management training for clinicians. Griffiths management reform is not just about a few doctors becoming general managers, but about all doctors becoming managerially accountable for the quality of their service and the resources they commit (Waters, 1985). The trend towards cost-efficiency and competition within internal markets further strengthens the case for the acquisition of effective management skills. The CTC working party report on management training (1990) provides a review of available alternatives and makes recommendations useful for those contemplating management training. Any trainee embarking on management training should consider very carefully the alternatives, assess their needs and determine their own aims and objectives. It is often necessary to choose and/or tailor an individual training package.

Even those "with a prioritised and single interest in clinical practice and research" need to realise that the acquisition of management skills is an on-going experience which starts early in one's career, and may usefully be supplemented by attending selected courses.

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DEAR SIRS

I was interested to read Dr Jadresic's article entitled 'Management Training – what do we need?' (*Psychiatric Bulletin*, February 1992, **16**, 86–87) where it was suggested that doctors might learn more about management by following a manager around for the day than on a formal course. I would support this suggestion for registrars/senior registrars, after spending a day "attached" to our Unit General Manager. It involved numerous meetings with many health professionals (clinicians and management) between 8.30 a.m. and 7.30 p.m. I came to understand much more about management issues, Trust funds and the skills involved in chairing meetings etc.

I also made my contribution, giving unsolicited advice on the dangers of excessive caffeine intake and hypoglycaemia. We didn't stop for lunch.

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Patient involvement in their psychiatric care

DEAR SIRS

In response to the concerns I raised in the wake of the MIND *People First* survey, Drs Phaterpekar and Abbott (*Psychiatric Bulletin*, February 1992, **16**, 112–113) suggest that I "should be reassured that considerable advances have been made with regard to patient involvement in their psychiatric care". May I make the following points?

(a) Local monitoring of satisfaction with services by those delivering care is confounded by the issue of power. A positive response bias is likely when people in hospital are asked their views by those who control their therapeutic fate and, in the case of formally detained patients, their liberty. Our survey was a research exercise, as we were independent of service delivery and this could explain why our data offer much less comfort to clinicians about the quality of in-patient services, as assessed by users. If psychiatrists are really concerned with service quality I hope that they give due attention to this in the research funding bodies they control. For instance, in the list of priorities set by the MRC committee looking at research into "schizophrenia" in 1988, service evaluation *to* patients (not by them) came a lame 8 out of 10 targets. Traditional

biological research was privileged in the higher items.

(b) Our findings about informed consent suggest that it is common for those recorded as of informal status on Department of Health statistics to report being coerced. The "hidden section" is well known to anyone working within psychiatry prepared to give an honest account of communications to patients. It is easy for clinicians to forget in their zeal to respond to those they deem to be ill that mental health law empowers professionals to operate a policy of preventive detention and detention without trial. Doctors may often believe that merely to identify mental illness is a good enough reason to treat it coercively. With such a cognitive set, it may be easy to overlook that locking people up against their will and without a trial (or merely having the power so to do) is hardly a conducive starting point for consensual decision making.

(c) Yes, physical treatments can be effective at symptom reduction. However, since the end of the 19th century it has been a rash psychiatrist who has claimed to "cure mental illness". Given the weak and contested evidence about the effectiveness of psychotropic medication yet the incontrovertible evidence about its iatrogenic effects, an ethical imperative exists to be open about the dangers of its use. For example, the difference in relapse between medicated and non-medicated (placebo) groups in the Northwick Park study was only 20%. In the first group 58% relapsed and in the second group 78% relapsed within two years. And yet, *all* of the recipients of major tranquillisers risk iatrogenic effects. Our anxieties are amplified when we look to the literature on polypharmacy, mega-dosing and irrational PRN policies, which potentiate iatrogenic effects and lead to unnecessary tardive dyskinesia, neuroleptic malignant syndrome and fatalities. When the latter occur among compulsorily detained patients, the cause for concern about human rights for those treated coercively with "dirty" pharmacological compounds becomes pressing. Shouldn't all users in every locality know about this picture when they are given neuroleptics?

(d) The very existence of a users' movement critical of what is currently delivered by services is testimony to the problems that the psychiatric profession faces. If patients are so grateful for what is offered, why do organisations like Survivors Speak Out exist and why do so many patients fail to comply with treatment? (The tautological explanation of the complainants being "mentally ill" is not a good enough answer to this question.) The emergence of a world wide new social movement, in protest against everyday theory and practice in psychiatric services, and the refusal of many patients to appreciate what is offered to them might indicate that some tough self-criticism, not bland reassurance, is required from the psychiatric profession.

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References are available on request to Dr Pilgrim.

Diogenes syndrome

DEAR SIRS

Dr D. V. Coakley's letter (*Psychiatric Bulletin*, **16**, 111) characterising a patient as suffering from Diogenes syndrome and proposing management based on this 'diagnosis', over-estimates the validity of the syndrome. The term 'Diogenes syndrome' is unsatisfactorily defined and needs further study before one can assume that psychiatrists treating such elderly recluses are merely "agents of social control".

Patients conforming to the description are diagnostically heterogeneous. Indeed, half the population from which Clark *et al* (1975) coined the term 'Diogenes syndrome' and ascribed personality and intelligence characteristics was dementing or schizophrenic though this is never made explicit! Even otherwise 'normal' self neglecting patients can have unsuspected pathology for example frontal lobe dysfunction. As it stands 'Diogenes syndrome' is a blanket term for a variety of social, physical and psychiatric disorders. On its own it is neither helpful in predicting outcome nor suggesting treatment.

The case referred to by Dr Coakley (*Psychiatric Bulletin*, 1991, **15**, 574) does not appear to be just a case of a woman who lives in a dangerous building whom the authorities want "out of sight". While self neglect in itself should not be a reason for admitting people, its existence should make us look carefully for treatable mental illness and enable us to rescue these people from appalling living conditions. MacAnespie (1975) points out that response to treatment can be good and only repeated assessment at home can help take the often difficult decision whether a patient should be admitted.

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