'failure' group though admittedly the latter was small. This study represents the situation in one American training centre but nicely illustrates that by considering 'overseas trainees' as an homogeneous group one overlooks those who are at least as good as the best of the indigenous trainees. The whole group too easily becomes 'labelled' by its least competent members.

Even if Dr Cox's conclusion is correct one should not assume that the fault lies with the trainees; it might be the trainers who must adapt their teaching methods to find that most appropriate to this group of students. Experience at Manchester suggests that the use of videotapes has a special contribution in this field.

Perhaps the term 'overseas trainees' has outlived its usefulness. As a result of our APIT survey we are beginning to appreciate that overseas trainees in psychiatry come from many different countries, have different backgrounds and motivations and experience a variety of different problems in this country both personal and professional. Only when these trainees come to be appreciated as individuals with their own strengths and weaknesses does their real contribution to our services become apparent.

FRANCIS CREED
MOHAN DAS
Members of APIT Committee.

Department of Psychiatry,
The London Hospital,
Whitechapel, E1 1BB

REFERENCE

(1) Weiss J. and Davis D. *Psychological Medicine* 1977, 7 311-316.

PRESCRIPTION CHARGES

DEAR SIR,

One of my chronic schizophrenic out-patients, a civil servant, has pointed out to me that the steep rise in prescription charges must inevitably affect the compliance rates of patients receiving maintenance medication. When, some years ago, representations were made concerning this issue, one of the problems which then arose was that the stigma attached to chronic psychiatric disorder could be reinforced by the statement of diagnosis on the prescription form if exemption from charges were sought. Another problem was the doubt expressed by some psychiatrists on the value of maintenance medication.

Apart from the fact that the charges often impose an intolerable financial burden on the disadvantaged psychiatrically disabled patient, they must act as an additional deterrent to compliance. Furthermore, this discrimination against this category of patient as compared, e.g., with diabetics and epileptics is in itself stigmatizing. The College might, therefore, consider making representations on behalf of this group of patients.

M. Y. EKDAWI
Consultant Psychiatrist

Netherne Hospital,
Coulsdon,
Surrey.

A similar letter from Dr R. K. Freudenberg appeared in the *Daily Telegraph* recently.

PSYCHIATRIC JOKES

DEAR SIR,

I am sure I am not alone in thinking that the lady referred to by Dr M. F. Hussain in the April issue of The *Bulletin* (p 68) and quoted from Freud's *Psychopathology of Everyday Life* meant exactly what she said, and what she meant was quite different from what Dr Hussain suggests.

N. H. N. MILLS

Gwent Health Authority,
Mamhilad,
Pontypool,
Gwent, NP4 8YP.

THE PRISON SERVICE INQUIRY

DEAR SIR,

I must protest about the College's evidence as put out in the *Bulletin* of May, 1979.

The point had been missed that joint appointments failed because neither the NHS and the Prison Service provided sufficient resources. The reasons given in the College's evidence were secondary to this.

The draft evidence quite fails to mention visiting psychotherapists (whose title it is proposed to change to visiting psychiatrists). It fails to appreciate both the role of and the enormous contribution made by visiting psychotherapists in the Prison Medical Service. If no visiting psychotherapist was on the group drawing up the College's evidence, then the College was in serious error.

It ill becomes those of us who work in the NHS to suggest that it is only medical services catering for separate minority groups that are giving a poor standard of care!

I find it difficult to read several paragraphs as other than being an attack on the reputation of our

colleagues in the Prison Service. Indeed, if applied to individuals the remarks could even be libellous. To say 'that Prison Medical Officers are in a unique position of diagnosing need and rejecting or selecting for individual services thereby applying the strictures or benefits of society' reads to me as if Medical Officers habitually, customarily or regularly neglect their professional duties in caring for their patients in order to subject them to greater suffering or humiliation. If that is not the authors' intention they should write more carefully. If they meant that, as in the NHS, demands for medical care are greater than resources available and doctors inevitably have to select between patients, then the memorandum should be rewritten to make this clear.

To suggest that the NHS is at this time at least capable of taking over the Prison Medical Service is to lose contact with reality. The NHS cannot cope with the task of its own psychiatric and other services; witness the recurrent scandals and problems partly due to an acute shortage of resources.

The criticism of the Prison Medical Service may reflect more the rejection of the service by the medical establishment than any action of that service. There is no doubt that the Prison Medical Service does not operate in a congenial environment, and many of its facilities are below reasonable standard. Perhaps the College should exert more pressure here, and this will indirectly aid recruiting.

I must ask the College Council to urgently reconsider the College's evidence. I personally repudiate it.

DAVID MARJOT

Visiting Psycho-Therapist,
H.M. Prison, Wormwood Scrubs
and H.M. Borstals.

THE PRISON MEDICAL SERVICE

DEAR SIR,

I have just read with incredulity and amazement the College's Evidence to the Prison Services Inquiry published in the May issue of the *Bulletin*. It seems that the document is ill-informed and biased and shows no comprehension of the Prison Medical Officer's unique role in an establishment. Furthermore, the implication comes over strongly that the Prison Medical Officer is in some way inferior and 'bent' by the system. Certainly the Prison Medical Service is a low prestige service on account of its poor working conditions and unattractive patients and therefore has some difficulty in recruiting, but this should not reflect upon the quality of Medical Officers who are appointed.

I comment on the section 'Deficiencies in Existing Prison Medical Services'. The report says that there is a tendency to reject and scapegoat prisoners so that services provided for them are often minimal. Certainly society has rejected them, but part of the Medical Officer's role is to combat that rejection. A prisoner reporting to a doctor is a patient, and is treated courteously and with respect as is any patient. The medical services available are exactly the same as for any other citizen with the exception of a choice of general practitioner. If the College recommendation to have all primary health care of prisoners provided by GPs were implemented the reality of the situation is that the prisoner would still not have the GP of his choice.

Regarding our working environment—yes it is poor and we too have had to work in old buildings and crowded conditions in the same way as our patients for far too long, but doesn't the very fact that we are there protect and safeguard against some of the possible well known effects of overcrowding? The full time Medical Officer is in close touch with staff and inmates whilst being independent of both and so is able to act as friend and confidant to both and mediator on occasions. Part-time Medical Officers are the first to agree that they cannot possibly pick up the atmosphere in the same way because they are not there for much of the day.

Contrary to what the Committee says, Prison Medical Officers are quite free to practise good basic psychiatry, including working with families and following up their patients. However, three factors curtail what we can do—

(a) shortage of auxiliary staff
(b) an administrative system which is unwieldy, poor at communications, and difficult to penetrate and harassment from members of our own profession and our own College who make insinuations of malpractice.

I trust the first two will improve following the Commission's report. The third might improve if colleagues became better informed by visiting us and talking to us about our work before passing judgment. I would welcome a visit from any member of the College Special Committee at any time.

Finally, regarding the Committee's recommendations—

(1) The NHS is floundering—why ask the Prison Medical Service to join a sinking ship!

(2) (a) Many general practitioners already provide primary health care on a part-time basis—they are the first to acknowledge that the presence