the profession needs to determine the scope of psychiatrists' responsibility before someone else decides for us. We would therefore urge the College to address this issue as a matter of urgency.

However, in the case we described, the management hinged on the fact that the patient was competent to make decisions about her treatment. The psychiatrist cannot over-ride her decision unless there are grounds for detention under the Mental Health Act and compulsory treatment.

JEANNETTE SMITH, *Fromeside Clinic, Blackberry Hill, Bristol BS16 1ED* and GWEN ADSHEAD, *Institute of Psychiatry, De Crespigny Park, London SE5 8AF*

Sir: When defensive practice becomes a replacement for good clinical practice our services become redundant. If Dr Davies and all my other colleagues support this maxim our professional survival is assured.

PETER TYRER, *St Charles' Hospital, London W10 6DZ*

Junior doctors and the drug management of disturbed behaviour

Sir: The survey by J.G. Cunnane (*Psychiatric Bulletin*, March 1994, **18**, 138–139) of consultant psychiatrists' opinions regarding drug management of acutely disturbed behaviour emphasised their lack of consensus, a fact which in itself is probably not surprisingly if the wide range of clinical scenarios and the myriad of available tranquillising medication is considered. However it was clear that chlorpromazine 100 mg intramuscularly was the most frequently advised treatment.

Both the *British National Formulary* (British Medical Association & Royal Pharmaceutical Society, 1993) and the data sheet for Largactil (in *ABPI Data Sheet Compendium*, 1993) state that the maximum i.m. dose for the relief of acute symptoms in an adult is 50 mg every 6–8 hours. The BNF does comment that "In some patients it is necessary to raise the dose of an antipsychotic drug above that which is normally recommended. This should be done with caution and under specialist supervision".

A recent document produced by the Royal College of Psychiatrists (1993) in response to disquiet regarding high dosages of antipsychotics states: "A junior trainee psychiatrist (SHO or registrar without MRCPsych) is not considered to be sufficiently qualified to take a decision to raise the dose of antipsychotics . . . above the recommended upper limit. This applies particularly in the emergency and acute situation . . .".

Immediate management of most acutely disturbed patients will be by such junior doctors, often out of hours, when there may be considerable need for swift and correct management decisions. They are clearly not considered to be specialists thus prescription of i.m. doses of chlorpromazine above 50 mg should not be made by juniors without the specific authority of a senior doctor. While this point may appear somewhat pedantic we practise in an increasingly litigious society and juniors who ignore such matters place themselves at risk. Much clearer emphasis should be made as to the utility of more potent neuroleptics such as droperidol and haloperidol when parenteral administration is required, as relatively much higher doses can be used when necessary.

ASSOCIATION OF THE BRITISH PHARMACEUTICAL INDUSTRY (1993) *ABPI Data sheet Compendium*, London: Datapharm Publications.

BRITISH MEDICAL ASSOCIATION & ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN (1993) *British National Formulary*, number 26, London: British Medical Association & The Pharmaceutical Press.

ROYAL COLLEGE OF PSYCHIATRISTS (1993) *Consensus Statement: the use of high dose antipsychotic medication.*

MARK MCCARTNEY, *Rampton Hospital, Retford, Nottinghamshire, DN2 0PD*

Sir: Dr McCartney's interpretation of this situation is substantially correct. In our document on high dose anti-psychotics we were concerned about junior doctors, who are not yet trained specialists, using doses of anti-psychotics in emergency situations above the suggested daily limits. We recommend auditing the practice of anti-psychotic prescribing in each psychiatric unit and suggest that appropriate policies are drawn up to ensure safety in the use of anti-psychotics.

CHRIS THOMPSON, *Chairman, Consensus Panel on the Use of High Dose Antipsychotic Medication*

Possible changes to the MRCPsych Part II examination

Sir: Having also recently sat MRCPsych Part II examination, I would like to comment on Dr Akinkunmi's letter (*Psychiatric Bulletin*, March 1994, **18**, 175). His proposal is to separate the written and oral/clinical part of the exam so that a candidate will be allowed to enter the second part only when there is a realistic possibility of passing the whole examination – like the MRCP. Each will be paid for by separate cheques and the 'doomed' candidate spared additional stress and unnecessary expense. However, more time will be necessary between the two parts and the more fortunate candidates will have to bear a longer episode of stress.

Which brings me to the Chief Examiner's response to the letter (*Psychiatric Bulletin*, March 1994, **18**, 175). However necessary the exam, as a threshold and a stimulus, it can also impede one's training. As a registrar one usually rotates through six month slots of psychiatric subspecialties. When the candidate sits the examination in one such period, with time off for a revision course and independent study leave, it is unlikely that he or she will have the energy or motivation to read up about the subspecialty he or she is attached to. With a pass rate of 195 out of 405 candidates this is likely to happen more than once.

Maybe registrar training could be organised like GP training; for example, a rotation of two years through different attachments like general psychiatry, child and family therapy, old age psychiatry, community psychiatry, learning disability and forensic psychiatry. Each could be examined in their own right, and date. This would enable registrars to study the subject they are working in and leave enough time for a three year higher psychiatric training and thus comply with 'specialist-training'.

R. STOCKING KORZEN, *Hillview Lodge, Royal United Hospital, Combe Park, Bath BA1 3NG*

Sir: I read with interest the comments by Akintunde Akinhunmi pertaining to the MRCPsych Part II examination (*Psychiatric Bulletin*, March 1994, **18**, 175).

The College rightly attaches the utmost importance to the clinical component of both examinations (Part I and Part II) leading to Membership. Candidates cannot pass unless the clinical is successfully negotiated. Perhaps it would therefore be more appropriate to exclude from the written papers candidates who fail the clinical. In its current form I believe candidates should not be excluded from the clinicals if they have already failed the written papers; in any case, I doubt if there would be adequate time to mark the written papers before the clinicals in the case of Part II. A further consideration are the criteria which need to be met for success in the examination. Currently a failure in the written papers does not mean automatic failure overall, providing the candidate passes the clinical; I believe it should stay that way.

I can understand the anxieties about the cost of the examination. The College has a duty to minimise these, while maintaining standards. Perhaps the activities of the examinations department could be audited and the results published annually in the *Bulletin*?

Performance in the clinical examination might actually be made worse by knowledge of success in the written papers (leading to heightened anxiety)!

Finally, I do not think it would be fair on candidates who are borderline if those who have clearly passed know their results first. The only way to speed up the processing of results would be to employ more staff – which would increase costs. I feel strongly that candidates should *not* be informed immediately if successful. There should be opportunity for reflection by the Examination Sub-Committee. For those candidates who have failed the examination, feedback on performance should be prioritised; some candidates have been receiving their feedback only days or weeks before their next attempt. This is clearly unsatisfactory.

STEPHEN M. JONES, *Norwich Psychiatry Rotation, West Norwich Hospital, Norwich NR2 3TU*

Sir: I note the points that Dr Jones makes and will make sure that these, together with other points made regarding the examination, are brought to the attention of the committee reviewing the examination.

SHEILA MANN, *Chief Examiner, The Royal College of Psychiatrists*

Mental Health Act (MHA) as an exam topic for the MRCPsych?

Sir: The issue of the need for training in the MHA arose from the recent Mental Health Act (MHA) Conference in London. Indeed, section 12 approval of psychiatrists does not include formal testing in the MHA. How better to encourage trainees to learn the MHA than to make it an examinable topic? The difficulty, as I understand, lies in the difference between Scottish, Irish, English/Welsh laws, and that there are candidates from Hong Kong.

I put the issue to my colleagues in the St George's Hospital Psychiatric Rotations (South West Thames Region). Fifty questionnaires were distributed to senior house officers and registrars and 40 responded; 11 had no Part I, 26 had Part I and 3 had Part II. Thirty-four were keen to have formal teaching in the MHA. Twenty-six (65%) rated their knowledge of the MHA as fair, 11 as 'poor' and one said he/she knew nothing! The most common source of knowledge was 'on-the-job' (93%) but 60% also who read up on the MHA. Among other sources of knowledge, one trainee included 'social worker', and another said 'lawyer'!

Twenty-eight (70%) wanted the MHA to be an examinable topic in the MRCPsych, while only nine said no, and three said they did not know. It was clear that the majority were recognising the importance of the MHA although, in this group of 28 trainees, six (21%) rated their knowledge of the MHA as poor.