Towards this objective, I would recommend the following rules:

(a) Questions about age, gender, race, nationality, place of birth, marital status and pre-professional education should not appear on application forms.
(b) No candidate who is not a member of the College may be shortlisted for a senior registrar or consultant appointment.
(c) If the only qualified candidates are non-white, the interviews should go ahead.
(d) Members of Advisory Appointments Committees should devise questions that would simply test a candidate's knowledge, skills and attitudes, and not refer to the candidate's ethnic or racial origin.

Having – in spite of my qualifications, experience and contributions to service provision and to education and training in psychiatry – had the personal experience of racial discrimination in my professional career in this country, I hope that our College will take the lead in encouraging non-racial thinking and in evolving a culture of genuine equality of opportunity.

IKECHUKWU O. AZUONYE, *Forest Healthcare NHS Trust, Claybury Hospital, Manor Road, Woodford Bridge, Essex IG8 8BY*

Sir: In 1987 Council established a Special Committee with the following terms of reference:

(a) to explore issues attending the training of psychiatrists and the practice of psychiatry in British multi-ethnic society
(b) to investigate the problems of discrimination against trainees, other doctors in psychiatry and patients on the grounds of race and to make recommendations.

The Special Committee, chaired by Professor Kenneth Rawnsley, presented its report to council in June 1989. Copies of this report are available from the College.

Twenty-four specific recommendations were made including the following "The College, perhaps through the Court of Electors, should ensure that regular monitoring takes place of the distribution by sex and ethnicity of new Fellows, Regional Advisers and their Deputies and examiners in the MCRPsych. Council accepted this recommendation but further agreed that there should be no discrimination by sex or ethnicity when members were being considered for membership of College committees, including the board of Examiners, for the Fellowship or for Distinction Awards".

The College obviously had information about the gender of its membership but no information on ethnicity. The College members were therefore circulated with a letter and a form from the Registrar collecting ethnic information in September 1990 and it has recently been agreed that this information should be regularly collected from new Inceptors, Members and Fellows of the College. Throughout this exercise the methodology and the classifications used have been the same as those which are used by the Office of Population, Censuses and Surveys which was updated for the 1991 population census. Further letters were sent out in January 1993 with reminders in July 1993.

Council reaffirmed its wish to collect ethnic information on its Members in 1993 and a working group was set up under the Chairmanship of Professor J. Cox to monitor the implementation of the recommendations of the 1987 Special Committee. Further, the establishment of a transcultural psychiatry special interest group may be expected to have a particular interest in the success of the ethnic monitoring service.

Members may wish to know that out of 5643 members and fellows residing in the United Kingdom, 1423 did not return their questionnaires, 65 returned blank questionnaires and 14 of these were accompanied by letters of objection. Seven completed questionnaires were accompanied by letters expressing strong support for the College's initiative.

With regard to Dr Azuonye's four recommendations, we are pleased to be able to report that these are in fact already College policy. College assessors on Advisory Appointments Committees attend a training day in which issues of equal opportunity feature prominently, both in didactic presentation and in role play. The College does not approve the appointment of a psychiatrist without membership to senior registrar, let alone consultant appointments, and takes firm action when this occurs without approval.

CHRIS THOMPSON, *Registrar*; and JOHN L. COX, *Dean, Royal College of Psychiatrists*

Shortage of beds

Sir: As a psychiatric registrar working in the same region, I agree with Dr Foster (*Psychiatric Bulletin*, June 1994, **18**, 371–372) that the shortage of acute beds is worsening. However, while this may pressurise juniors to avoid admissions, I do not share the sense of inevitability conveyed by her letter. This situation only arises when juniors allow wider managerial issues to cloud clinical judgement. Junior doctors are not in a position to deal with such issues unaided and attempts to do so may expose patients to increased risk while possibly exacerbating the underlying problem of insufficient beds.

If a junior attempts to avoid a bed crisis by sending home patients for whom in-patient care is indicated and the consultant responsible is not made aware, this distorts the pressure on the service perceived by consultants and managers. It could be postulated that such action by juniors creates an impression of a reduced requirement for beds thus facilitating further mismatch between need and service.

I do not even agree that it is part of the job of a junior doctor to know the bed state. If the decision has been made by a junior to admit a patient then surely it is the job of a designated bed manager to find a bed. If no beds are available then the duty consultant should be asked for advice. It is down to the junior to resist taking responsibility for risky decisions and to pass it back to those with more experience.

MICHAEL SHAW, *Leighton Hospital, Middlewich Road, Crewe CW1 4QJ*

Sir: In response to Frances Foster (*Psychiatric Bulletin*, June 1994, **18**, 371–372) I agree that the current bed shortage throughout the country is cause for concern, not least with junior medical staff.

In addition to the consultant psychiatrist taking fewer risks and delaying discharge, in my experience this has now extended to the Mental Health Review Tribunal who appear increasingly cautious with regard to discharging patients from hospital. This too is exacerbated by lack of finances and facilities available to the social services in the community.

Indeed, despite the policy of closure of many large psychiatric institutions, and even further reduction in the number of available hospital beds and increasing emphasis on community care, the pendulum has begun to swing in the opposite direction. More in-patient facilities will inevitably be needed in the future to accommodate the increasing caution within the field of psychiatry unless this trend ceases.

STEPHEN NOBLETT, *Fazakerley Hospital, Liverpool L9 7AL*

Sir: We read with interest the letter from Dr Foster concerning bed shortages (*Psychiatric Bulletin*, June 1994, **18**, 371–372). Acute psychiatric beds are becoming an increasingly scarce and precious resource.

We disagree that a reluctance by consultants to discharge patients is the prime cause of such a shortage. There are many other causative factors. Bed closures, inadequate community resources and time spent finding accommodation for the difficult to place chronically mentally ill, combined with a failure to acknowledge their long-term needs, must all play a part.

We agree that bed scarcity does place extra pressures on junior staff, particularly when they are on call. We also experience recurring difficulty in finding vacant beds for patients. This necessitates the risky use of leave beds and even the emergency placement of relatively young patients on psychogeriatric wards. The decision whether or not to admit patients is inevitably influenced by the bed state. Even before assessing patients in the accident and emergency department there can be pressure not to admit them to hospital because of bed shortages and to depend instead on community resources, however inadequate and inappropriate they may be. Risk taking is inevitably devolved to junior staff.

We agree with Turner (*Psychiatric Bulletin*, 1994, June, **18**, 371) that the Mental Health Act does not create an incentive for discharge. The use of acute psychiatric beds for detained or informal patients, while waiting community resources to be identified and funded, is in our view an inappropriate but recurring use of an increasingly scarce resource.

K. SILLIFANT and J. O'DWYER, *High Royds Hospital, Menston, Ilkley, Leeds LS9 6AQ*

Mental Health Review Tribunals

Sir: We read with interest the correspondence by Green & Wallis (*Psychiatric Bulletin*, June 1994, **18**, 374) and Wood (*Psychiatric Bulletin*, June 1994, **18**, 375) regarding attendance of the Responsible Medical Officer at Mental Health Review Tribunals.

The tribunals should not be used to 'pass the buck'. However, the circumstances in which the RMO may be seen to be doing so vary. For patients detained under section 2, there is very little time between detention under the Act, applying to the tribunal, the RMO's appraisal and hearing by the tribunal and it would be unwise for the RMO to revoke the Order before the tribunal hearing unless the patient is 'cured' in that short period.

The difficulty arises with patients detained under section 3 and 37 of the Act. The RMO should not wait for an application or a reference to the tribunal to be made before considering the patient's discharge and this should be seriously considered at the time of the renewal of detention, endorsed by hospital managers. One of us (AK) attended 47 tribunals for patients detained under section 3 and 37 under his care over the past four years, not recommending a single discharge and the recommendations were upheld in each case.

The experience of Green & Wallis cannot be generalised to most psychiatric hospitals because of their highly selective patient group