

length of addiction. It is not possible to argue from a single case, nor, perhaps appropriate to bet on such a serious issue. We are currently preparing a report on more than 30 addicts treated according to our protocol, and most of our 'chaotic' addicts have also had healthy babies at term.

Addiction to injection may be less important now in the climate of anxiety about HIV infection. However, injectable methadone is not licensed for intravenous injection, and causes thrombophlebitis and the risk of septicaemia when used in this way. The few patients on injectable methadone in our series have been willing to change to oral medication when the dangers have been explained.

Her statement that it can be 'morally responsible' for the parent to treat her own child with opiates is in itself so irresponsible as to require no further comment, especially in view of the increased incidence of neonatal death in these infants. Paediatricians use chlorpromazine or phenobarbitone to treat the infants because these are relatively safe in the neonate, and do not have the low lethal threshold of opiates. Surely few lay people are experienced in neonatal pharmacokinetics, and infant deaths from opiate poisoning have been reported.

That parents do treat their babies in this way because of 'lack of confidence in their professional advisers' is no excuse. The cornerstone of successful treatment is a trusting relationship between doctor and patient. The plan of treatment is openly negotiated, and the reduction carried out with the patient's full agreement. Good ante-natal care, social support, and flexibility of dosage are part of the total plan.

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Professor Edward Anderson

DEAR SIR

I was very interested to read the interview with Professor Rawnsley which appeared in January's *Bulletin*. I was particularly pleased to note that he has set the record straight regarding Professor Anderson, who in my opinion also has been much under-estimated. I think Anderson must be credited with a large share of the interest that has developed in recent years in the work done by German-speaking psychiatrists, particularly such figures as Kurt Schneider. He also played a considerable role in making known to us the importance of phenomenology in psychiatry and in particular the contribution of Karl Jaspers. He had a great influence on postgraduate students in Manchester and although he worked in a very modest department, his teaching had a profound and lasting effect on British psychiatry, which he enriched with the treasury of continental scholarship.

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Canadian qualifications for British psychiatrists

DEAR SIR

Further to our recent correspondence on the above subject (*Bulletin*, January 1988) it has come to our attention that the Canadian Royal College of Physicians and Surgeons has recently implemented a further prerequisite for non-North American psychiatrists in respect of their eligibility to take the FRCP (Psych) examination. It is now required that all non-North American psychiatrists complete a one year rotating internship (in UK terms house officer status) of the North American type, in order to attain eligibility for this examination. This is in addition to the other mandatory requirements of passing a North American screening examination and having one's psychiatric training assessed by the Royal College. The need for this internship, however, may be bypassed if one passes an oral examination of clinical competence organised by a Canadian medical school. While this examination of 'clinical competence' is now available for non-North American psychiatric trainees in Canadian residency programmes, it is not clear, as yet, as to whether physicians outside such residency programmes will be able to avail themselves of this assessment.

We regret that this information was not present in our earlier letter. It does, however, present yet a further significant hurdle to UK psychiatrists achieving Canadian psychiatric qualifications, which we feel British trained psychiatrists considering a career in Canada should be aware of.

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The need for asylum

DEAR SIR

I cannot rival the eloquence of Drs Garelick and Abrahamson in their complementary papers in February's *Bulletin*. I do, however, wish to support fully the ideas they put forward.

Dr Garelick's account of the local planning process makes extraordinary reading with regard to the lack of weight given to clinicians' opinions in the process. Both he and Dr Abrahamson make a compelling case for the need for asylum as part of the psychiatric service, in turn Dr Abrahamson suggests that the apologetic tone of the consensus statement from the Third Kings Fund Forum is ill-judged.

The reality is that many patients (not clients, consumers or recipients) are crippled by severe psychiatric illness (not merely distressed). I much prefer the medical paternalism which is prepared to state what such patients need (in some cases long-term hospital asylum) to the arrogance of the self-styled patients' advocates who claim to know what they want without benefit of any face-to-face contact.

We are fortunate in Scotland in that whatever difficulties

there are in our services, by and large we have sufficient capacity still to offer asylum where it is needed and we must jealously guard this. It may be by doing so colleagues in other parts of the UK can take heart in their efforts to preserve crucial parts of their services.

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Professor Michael Simpson

DEAR SIRS

I was glad to see Dr S. E. Baumann's letter (*Bulletin*, February 1988). I share his views. I lived and worked as a South African citizen for 10 years, including service as a medical missionary in Natal and later as a medical officer in a military hospital for African (black) soldiers in the Middle East. I think I understand the problems of facing both racial sections in South Africa.

The excesses of the Nationalist Government since its coming to power in 1948 have been indefensible; these must be put right and more than that must be done. The risks the white population feel of finding themselves to be secondary citizens in an almost alien land are equally frightening to them. The average European in South Africa is little better and probably no worse than his brothers or sisters in Britain and Europe and is less self-righteous than many of his British kith and kin. An academic boycott will not clear up the mess; we need something more searchingly inventive and more purposeful than this.

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Psychological aspects of nuclear war

DEAR SIRS

In the wake of the Reagan–Gorbachev summit I would like to invite readers to consider the important part psychiatric and psychological opinion might have to play in the outcome of future nuclear arms reduction negotiations.

It has been suggested that the conflict between the superpowers, which maintains the nuclear arms race, can be seen as an expression of comprehensible intergroup interactions that could be modified.¹ The events of recent months may well be seen by future historians to have been a critical beginning to that process. Nevertheless this is a fragile process and further progress towards peaceful co-existence could just as easily be blocked by the arguments and activities of those whose interests, ideological or material, conflict with that end.

One of the arguments used to maintain the legitimacy of military expansion is that aggression and violence are inevitable consequences of man's nature. This view is certainly not held universally and many argue that it is frankly misleading.

Some two years ago a group of prominent behavioural scientists met in Seville to draft the Seville 'Statement on

Violence'. The statement is in fact a series of statements outlining expert opinion of current scientific views of human aggression. The statements, substantiated in the original,² are as follows:

'It is scientifically incorrect to say that we have inherited a tendency to make war from our animal ancestors.'

'It is scientifically incorrect to say that war or any other violent behaviour is genetically programmed into our human nature.'

'It is scientifically incorrect to say that in the course of human evolution there has been a selection for aggressive behaviour more than for other kinds of behaviour.'

'It is scientifically incorrect to say that humans have a "violent brain".'

'It is scientifically incorrect to say that war is caused by "instinct" or any single motivation.'

The precedent this statement follows is the UNESCO 'Statement on Race' which has been widely disseminated in a variety of versions and has had a considerable influence on public policies towards racial matters. It is hoped to persuade as many organisations as possible to acknowledge the validity of the Seville 'Statement of Violence' and the Royal College of Psychiatrists should be amongst them.

Another related area in which the opinions and activities of psychiatrists and psychologists might influence public opinion is the study of anxiety and nihilism expressed by adolescents confronting the possibility of nuclear war in their lifetime. There are now several publications documenting this phenomenon and a great deal of active research. Yet another might be the psychology of individuals and organisations responsible for maintaining and, in the event of war, actually using weapons of mass destruction.

The American Psychiatric Association now has a Committee on the psychological aspects of nuclear issues mandated to review and report upon relevant research and opinion. Such politicking is not usually popular amongst British professional people, but again it is not without precedent. The British Medical Association has published a report on the medical effects of nuclear weapons and the British Psychological Association has endorsed a book about the psychological aspects of nuclear war. It is one of the responsibilities of professional bodies to ensure that public opinion of issues in their domain is accurately up to date. Current public opinion and current scientific opinion of the psychology, causes and consequences of group conflict do appear to be significantly out of step. If there is a British organisation responsible for guiding public opinion in this area then it must be the Royal College of Psychiatrists. Perhaps the College should follow the example of the APA and set up a body to review relevant research, agree policy and make its opinions known.

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REFERENCES

¹*Medicine and War* (1987) 3, 11–23.

²*Medicine and War* (1987) 3, 191–193.