identified general and old age JPAC quotas. It is necessary to monitor posts that come 'on the market' and the departures that release them on an annual basis – so that training opportunities can be modified in response to actual as opposed to planned need.

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Reference

JOLLEY, D. (1988) England expects: are we prepared? *Bulletin of The Royal College of Psychiatrists*, **12**, 102–103.

Psychiatry and the private sector

DEAR SIRS

As a consultant psychiatrist, working in one of the more notoriously deprived inner London boroughs, I was saddened at Dr Birley's response to the open letter objecting to a session on Private Psychiatry at the Autumn Quarterly Meeting (*Psychiatric Bulletin*, December 1988, **12**, 554). The key points made by the letter's signatories were the non-academic aspects of the topic, the promotional interests of some of the speakers, and the NHS as "the only option for the vast majority of our patients". To reply with unnecessary defensiveness, that "private care is a legitimate business" – whoever said it was not? – and that it "makes a contribution to the care of our citizens" is banal and beside the point.

The key question is whether private practice, *per se*, has any particular academic contribution to make to psychiatry that cannot be, or is not being, made in the NHS. The subsidiary, but equally vital, point is the economic status of those suffering from significant mental illness which by definition largely puts them out of reach of private care. This is not a "matter of debate" but an established aspect of social psychiatric research.

What I find so annoying about modern private psychiatry is the false hope and guilt engendered in patients and relatives, who fear that if they just paid enough money a chronic schizophrenic illness would somehow be resolved. Those unable to think clearly or judge appropriately, because of illness, are especially vulnerable to such notions. Yet never once has a private practitioner contacted me or my colleagues for a detailed background history of patients well-known to us, yet referred by, for example, an inexperienced GP or GP locum.

In my experience the main contribution of those working in the private sector has been despair, not care. The contrast between the crumbling Victorian infirmary in which I write and the glossy brochures of new private hospitals is especially discomforting. Were they to consider researching such aspects of the outcome of private referral, I might be prepared to listen to their presentations.

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DEAR SIRS

As one who has for many years worked solely as a private practitioner in psychiatry, I can still have some sympathy with and understanding of the concern expressed by Appleby *et al* (*Psychiatric Bulletin*, December 1988), although I feel that their expression of it does not really reflect the basis for their distaste and is a little inappropriate.

It must surely be agreed that the prime objective of psychiatry (as indeed of all other branches of medicare) is to provide the best possible service to the patient. The method of remuneration should be immaterial. Thus psychiatry in private practice is in general not characterised by problems that do not arise in any other community-based service and as such is not a separate academic discipline. However, the same is true of practice in a Government service.

The consideration of the nature and funding of services and their impact on treatment is a legitimate object of scientific study and in psychiatry dates from the time of Freud.

Any sessions that meet this criterion will not affect either our academic reputation or our ethical one.

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A medical member's analysis of 50 patients at the Mental Health Review Tribunal

DEAR SIRS

As a medical member of the Mental Health Review Tribunal (MHRT) for Yorkshire, I have analysed a series of 50 consecutive cases that I have examined in the four-year period 1985 to 1988.

Findings

Sex: There were 26 men and 24 women, total 50.

Age ranges: Twenty-two (15 men, seven women) were in the 20 to 35 age range, including 14 (nine men, five women) aged 26 to 30. Seven (four men, three women) were in the 36 to 40 age group. Twenty-one (seven men, 14 women) were aged from 41 to 85, including one woman in the 66 to 70 age group, one woman 71 to 75 and one woman 81 to 85.