My own view is that the Advisory Service should in fact be strengthened with statutory powers, both to restrain the stiffling effect on the development of conterminous district services due to the voracious demands of academic departments for staff, the justification for which would appear to be patient flow figures which largely reflect the absence of a local service in the deprived conterminous districts as well as the need to promote adequate provision of Local Authority resources for the mentally ill by those Authorities which would appear to be reluctant to countenance the development and provision of a truly comprehensive mental health service which reflects current models of good practice.

IAN STOUT

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DEAR SIRS

The letter from the Director of the Hospital Advisory Service (*Bulletin*, May 1986, **10**, 115) and his subsequent article (*Bulletin*, June 1986, **10**, 145–6) enshrine some misapprehensions about its approach.

His claims that the HAS 'does not hold strong beliefs' and that 'there is no HAS philosophy' are surely disingenuous. Its organisation is based on belief in a multi-disciplinary approach, which he vigorously reaffirms, that is no less a philosophy for being by now conventional. A range of beliefs such as that 'psychiatry is essentially a community speciality' underpin other aspects of its activities and inevitably so; it is hard to see how it could function without what is in effect a philosophy, however loosely articulated.

Equally, the claims that HAS team members have no axes to grind and are unencumbered by local history and politics conflict sharply with the experience of many of those visited. Indeed, the last few lines of his letter confirm how easy it is to become sucked into the host District's politics; and they are certainly not unencumbered by the history and politics of their own districts.

It is surely time for the HAS to accept that a range of assumptions inevitably underlie its teams' activities, rather than continue to pretend to itself and others that none exist. The Director of an organisation that expects others to examine their preconceptions should not be so complacent about its own as to suggest it has a 'proven system' and to offer no choice except more of the same or replacement by an inspectorate.

The third alternative is surely for the HAS to stimulate reviews, debate and research on themes which underlie its approach and on the effects of its interventions on the development of mental illness services. Its 'direct line' to ministers might appropriately be used to fight for the resources required.

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ECT on OPD basis

DEAR SIRS

It is surprising to learn from Dr Snaith's letter (*Bulletin*, March 1986, **10**, 55) that out-patient ECT is administered sparingly in the UK because of fear of mishap, disaster and so forth. I wish to support Dr Snaith's views and say that, in India, ECT is administered on an out-patient basis at most centres. In my centre, which is a postgraduate department, modified ECT has been given on an out-patient basis for over 25 years without mishap. Written instructions for pre- and post-ECT care are given to patients and relatives, who follow them well, even though less educated than those in the UK.

Out-patient ECT is more acceptable to patients and their relatives because admission, which has social stigma in our country, can be avoided. Thus many early cases can derive its benefit. Moreover in India out-patient ECT is less expensive than in-patient ECT where there are a very limited number of psychiatric beds (25 000 only) anyway.

Hence for various reasons such as more acceptability, low cost, wide coverage and practically no risk, out-patient ECT merits more use. Otherwise many patients in the community will be deprived of an effective and safe therapy.

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MRCPsych Preliminary Test

DEAR SIRS

I write to express my increasing disquiet with the MRCPsych Preliminary Test. Not one of the junior doctors at my hospital passed this exam last time round. This might not have caused much surprise seven years or more ago when it was difficult to attract good doctors to work in large mental hospitals. However, times have changed; Long Grove is now linked to St George's Hospital for general psychiatric training and as a consequence of this link with one of the most highly rated training schemes in London, we are now able to attract many outstanding young doctors. In addition, the College has been most influential in increasing the attractiveness of psychiatry as a speciality, with the result that many of the best and brightest products of British medical schools are opting for a career in psychiatry.

So, if our trainees are so talented, enthusiastic, hard working and conscientious, as I believe they are, how is it that not one of them passed this Preliminary Test?

The only feasible explanation seems to be that the proportion of candidates who 'passed' the exam is fixed, so that regardless of standards, only a certain number of people can be allowed to get through each time. If true, I believe this situation to be unfortunate, if not demoralising and potentially destructive.

When the College established the MRCPsych and Preliminary Test to supersede the DPM it essentially modelled it on its predecessor. The ideal of the Preliminary Test, as I understand it, was to stimulate study of the basic