the barons and their retainers works for the good of the country. When the monarchy is weak the barons tend to fight amongst themselves, the stronger ones taking power, land and resources from the weak.

The old age psychiatry barons (amongst others) are short of retainers. Their bid for status as a psychiatric specialty is like looking to the king for support. It may be their due but I wonder if the monarchy is strong enough to redress the imbalance of power?

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References

[1]JOLLEY, D. J. (1988) England expects: Are we prepared? *Bulletin of the Royal College of Psychiatrists*, **12**, 102–103.

[2]WATTIS, J. P. *et al.* (1981) Psychogeriatrics: a national survey of a new branch of psychiatry. *British Medical Journal*, **282**, 1529–1533.

[3]WATTIS, J. P. & ARIE, R. (1984) Further developments in psychogeriatrics in Britain. *British Medical Journal*, **289**, 778.

[4]JOLLEY, D. (1985) (letter). *British Medical Journal*, **290**, 240.

[5]WATTIS, J. P. (1985) (letter). *British Medical Journal*, **291**, 1281.

Return of abused children to their parents

DEAR SIRS

I was greatly concerned by some of the points made by Dr Asen in the article describing the activities of the Marlborough Family Day Unit (*Bulletin*, March 1988, **12**, 88–90). He stated that Social Services frequently requested the unit to assess whether an abused child or children should be reunited or permanently separated from their family.

Whilst numerous risk factors have been identified in parents who abuse their children, much less work has been done to identify which parents will re-abuse their children once they have been returned to them. However, it is said that 10% of children die as a result of the abuse, 25% may become mentally retarded and 60% will be re-abused.[1] Therefore, the decision to return an abused child to his or her parents must never be taken lightly, but should this be a medical or psychiatric decision?

It has been estimated that less than 10% of abusing parents have evidence of formal psychiatric disorder.[2] So it is reasonable to ask whether psychiatrists have anything to offer the majority of these people who are not mentally ill?

The author told us that family systems psychotherapy is the treatment strategy used at the Marlborough Day Unit. However, further on in the article it became clear that some parents will have engaged in therapy with the knowledge that good behaviour at the unit could lead to a recommendation being made that their children should be returned to them. Surely this is not the basis on which psychotherapy should be undertaken. We were also told that "Social Services are required by us to put in concrete language ... what sort of changes they would need to see for them to be sufficiently convinced that the parents could have their children living with them". I would argue that we do not know the answer to this question, other than the obvious: not to abuse their children.

A day hospital staffed with psychiatric nurses, a visiting psychiatrist, and a social worker is hardly a 'normal' environment in which predictions can be made about how parents will behave in their own homes. Such an activity is nothing more than speculation.

Child abuse is an evocative subject and one that provokes a desire to help and protect. The decision to return an abused child to his or her parents is essentially a moral problem. I would argue that in the majority of cases psychiatrists do not have any expertise in this area and to offer a professional opinion would be unethical. It is up to the courts to make this decision and psychiatrists should not be seduced into making pseudoscientific predictions made in an artificial environment and based on little or no scientific evidence.

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References

[1]HILL, P. (1986) Child psychiatry. In: *Essentials of Postgraduate Psychiatry*. (eds. P. Hill, R. Murray & A. Thorley). London: Grune & Stratton.

[2]PARKE, R. D. & COLLMER, C. W. (1975) Child abuse: an interdisciplinary analysis. In: *Review of Child Development Research*, Vol. 5. (ed. E. M. Hetherington). Chicago: University of Chicago Press.

Dr Asen replies

DEAR SIRS

I would like to make the following points in response to Dr Dunn's letter.

(1) When Dr Dunn wonders whether psychiatrists have anything to offer in child abuse cases, he entirely overlooks the possibility that physically abused children may also be suffering from related psychological disorders. Almost all of the abused children referred to the Marlborough

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Family Day Unit present with severe emotional and/or behavioural disorders. This alone would seem to justify the involvement of a (child) psychiatrist in child abuse cases, both for assessment and treatment purposes.

(2) Dr Dunn appears to be unaware of a large body of work by child psychiatrists, social workers and allied child care professionals who have over the years attempted to establish reliable ways of assessing the likelihood of re-abuse (some of it summarised in[1]). To state, as Dr Dunn does, that we do not know what the behaviours are that may lead to rehabilitation, other than "not to abuse their children", shows a somewhat limited understanding: the actual act of abuse is not an isolated phenomenon but only one (though probably the most severe) symptom of inadequate or "dangerous" parenting.

(3) To suggest that the decision to return an abused child to his home "is essentially a moral problem" is worrying: whose morals anyway? Courts in fact request child psychiatrists to provide more objective information[2], not "pseudoscientific" or moralistic statements.

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References

[1] ADCOCK, M. & WHITE, R. (eds) (1985) *Good-Enough Parenting: A Frame-work for Assessment*. Practice Series 12. London: BAAF.

[2] BRITISH AGENCIES FOR ADOPTION AND FOSTERING (1984) *Taking a Stand: Child Psychiatrists in Custody, Access and Disputed Adoption Cases*. Discussion Series 5. London: BAAF.

Psychiatric ward rounds

DEAR SIRS

Dr McBride (*Bulletin*, February 1988) addresses the format and use of ward rounds.

I would propose that, just as there is no single formulation for a patient, there is no ideal ward round which is applicable to all situations.

General psychiatry is very different to some of the sub-specialities. In child psychiatry one ward round a week is adequate; however the presentation of a new case may take up to an hour with various disciplines contributing. On a general ward where there is a rapid through-put I feel two rounds a week are preferable, perhaps with one being a mini-round conducted by the SR.

I feel it is wrong to divorce teaching from the ward round. All the disciplines have much to learn from each other; thus the consultant is not always the teacher, nor the registrar always the pupil. Academic psychiatry is better understood and remembered when learned in a clinical setting. If patients are to be spared the trauma of being interviewed in the round then they should be seen both before (to ascertain mental state) and after (to inform). The cohesiveness of any team will be eroded if any member ignores the team plan; a doctor is more likely to be guilty of this if he fails to assess the patient adequately before or during the round.

The timing of a round will depend on local factors. Although the morning is busy, a round then permits investigations, phone calls and letters to be completed by the end of the day.

There is no 'correct' format for all rounds but Dr McBride's article has prompted many of us to criticise them for the first time.

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The College and South Africa

DEAR SIRS

When Christian Barnard pioneered the first heart transplant, Malcolm Muggeridge, during a televised debate, repeatedly asked "Why South Africa?". It might now be appropriate to ask "Why the Royal College of Psychiatrists?", as the British Psychological Society and the London Colleges of Physicians and Surgeons, among others, have not been similarly prompted to encourage, in effect, an academic boycott of that country. Its value in promoting stabilisation and the over-due abolition of apartheid is debateable, to say the least. According to Professor Simpson (*Bulletin*, April 1988) Fellows continue to make well-funded visits to give presentations "usually irrelevant to our real professional problems". What is the motive behind this posture of the College?

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Part-time training in psychiatry

DEAR SIRS

Some of my colleagues and I are becoming increasingly concerned about the difficulties experienced by those doctors (usually but not only women with children) who want to train in psychiatry on a part-time

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