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# Correspondence

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## Drugs, information and influence

Sir: The interesting paper by Babor *et al* (*Psychiatric Bulletin*, July 1996, **20**, 406–409) tentatively offers reassurance about the influence of advertising, but the need for caution remains.

Drug companies may spend over a million pounds on marketing a new product and it therefore seems surprising that doctors in this study felt almost immune from the influence of advertisements in their prescribing. As with most sophisticated consumers, doctors are unlikely to respond to direct product-orientated advertising. Drug companies are highly sophisticated advertisers and are aware of such consumer characteristics. They will plan advertising, within an overall marketing strategy, to fulfil a number of different functions including: making an impact, creating product awareness, changing perception, reinforcing attitudes and long-term brand awareness (D'Souza, 1989). They will seek to target specific doctors with the greatest influence, for example consultants who may be involved in developing hospital formularies, which may then become secondary advertisements.

It is then tempting to view advertisements as manipulating the consumer into making inappropriate choices and therefore undesirable. However, psychotropic advertisements are more complicated and have been shown to serve an orienting and therapeutic function for physicians, mirroring and supporting professional identity (Neill, 1989). Advertisements are also perceived as helpful in allowing doctors to keep up with new developments (Crown, 1996).

The subtlety and interactive nature of the advertiser's message needs to be fully appreciated and a failure to consistently demonstrate linear causal relationships does not exclude a powerful influence.

CROWN, S. (1996) Advertising in psychopharmacology. *Psychiatric Bulletin*, **20**, 370.

D'SOUZA, S. (1989) The roles of advertising. In *How to Plan Advertising* (ed. D. Cowley), pp 13–40. London: Cassell Education Limited.

NEILL, J. R. (1989) A social history of psychotropic drug advertisements. *Social Science and Medicine*, **28**, 333–338.

TIM MORRIS, *Wirral Community NHS Trust, Adcote House, Columbia Road, Wirral L63 6TU*

Sir: I write in response to the letter from Sidney Crown, *Psychiatric Bulletin* (June 1996, **20**, 370),

concerning the booklet *Highlights – Managing Depression with the Whole Patient in Mind* prepared by Lundbeck Limited. As a post-conference summary, this document was intended to provide notification of the meeting's content and findings in abbreviated form, ahead of the full publication, which has now been published (Leonard & Montgomery, 1996).

Much of the meeting was based around published data, however, the forum was used to present new data, including a comprehensive review of the safety and tolerability of citalopram.

The provision of data in summarised form in advance of full paper publication is well established. As this meeting used innovative technology to record the views of more than 350 UK psychiatrists on topical issues in the management of depression, we felt the results would be of particular interest to the wider community of psychiatrists. I should also point out that all the speakers concerned had an opportunity to review the summary of their presentation before distribution. I hope this clears up any misunderstanding concerning the objective of this booklet.

LEONARD, B. & MONTGOMERY, S. (eds) (1996) *Managing Depression with the Whole Patient in Mind*. Papers presented at an interactive focus conference, 2 and 3 June 1995. *International Clinical Psychopharmacology*, **11**(Suppl 1), 5–50.

CHRIS MULDOON, *Medical Director, Lundbeck Limited, Caldecotte, Milton Keynes MK7 8LF*

## Child mental health

Sir: I feel I must object in the strongest terms at both the style and content of Dr Bartlet's article "School pressures and child mental health in Afro-Asian countries" (*Psychiatric Bulletin*, 1996, **20**, 301–303). While I agree that poor resources and poverty have many consequences in both education and children's mental health, I believe Dr Bartlet has not only misunderstood these dynamics but in addition the portrait painted by this article is racist and offensive.

My first objection is to the category 'Afro-Asian'. Dr Bartlet jumps around these two vast and diverse continents citing examples from many countries. These examples are then compared (unfavourably) to the West. Economic, cultural, social, and geographical differences between these countries are as great as between these countries and Western countries. If the point was

to compare 'rich' and 'poor' countries, why are Japan and other South East Asian countries included and Latin American countries excluded? Such a category cannot impart meaningful information.

Starting from this grave category error, the result is an article full of content errors. Lack of affective expression may be true in Japanese culture but is not true of Middle Eastern culture. Many traditional Asian medical systems fully recognise the link between mind and body. Bullying may be a problem in some schools, but certainly not more so than in the West. Suicide rates in the young are as variable between Afro-Asian countries as they are in the West. Parents not listening to children is not a consequence of culture and can happen in any culture.

SAMMI TIMIMI, *Department of Psychological Medicine, Great Ormond Street Hospital, London WC1N 3JH*

**Author's reply:** The article was an attempt to record the observations and anxieties about some of the pressures that were brought to my attention by colleagues in mental health, paediatricians and educationalists in the course of overseas attachments since 1978. The article is unscientific and my first hand experience of children under these pressures is very limited. It was the recurrence of the theme in India, Pakistan and Thailand in particular that moved me to write.

Dr Timimi infers that I (or my subconscious) believe that Western parents know how to do all the right things by their children. I would point out that I allude to pressurising in worldwide and British contexts in the first paragraph. Dr Timimi is wrong in suggesting that I invoke Western child psychiatry to solve this problem. All the ideas I mention are from the recommendations of the 1978 WHO report *Child Mental Health and Psychosocial Development*. This excellent document is antipathetic to expensive Western style child psychiatric services and favours the development of basic mental health skills and primary care levels.

Thirteen years ago I wrote in the *Indian Journal of Psychiatry* that "the adoption of Western child psychiatric practices will need to be watched very carefully. Child Psychiatry must be related to society and culture – possibly more so than in any other specialism". I still hold this view.

LESLIE BARTLET, *Paediatric Department, Southampton General Hospital, Southampton SO16 6YD*

### **Procedures for Election to the Fellowship of the Royal College of Physicians of London**

Sir: I am writing to correct a statement regarding the mode of election to the Fellowship of the Royal College of Physicians of London. In his recent article in the *Psychiatric Bulletin* (1996, **20**, 185–187) your Registrar indicated that election to our Fellowship was 'almost an automatic entitlement'. This is not the case. Although all Physicians working in England and Wales who have been in a Consultant post for three years or more are automatically considered, they are by no means automatically elected; indeed the overall success rate, which includes this group as well as Members who are not Physicians or work in other countries, runs at approximately 50%. In order to be elected, a candidate has to satisfy one or more defined criteria in addition to the 'good standing and reasonable seniority' suggested in your article. We regard our Fellowship as a mark of distinction, as indeed it is so described in our Bye-laws. I hope that this brief explanation will clarify the situation for your readers.

DAVID LONDON, *Registrar, Royal College of Physicians, 11 St Andrews Place, London NW1 4LE*

### **Parole board guidelines**

Sir: I refer to the article "Parole board guidelines" in The College section of the May 1996 issue of *Psychiatric Bulletin* (**20**, 315–316). I decided to put these guidelines into practice recently when preparing a report on a life sentence prisoner. When the typed report came back for signature the Senior Medical Officer of the prison pointed out that the report did not conform to the official guidelines and so he had inserted headings at intervals through the report in order to make my report match his guidelines. He gave me a copy of the headings which are required to be used in reports and they are as follows:

- (1) knowledge of the prisoner – including your qualifications
- (2) attitude to the offence
- (3) insight into offence related behavioural problem
- (4) behaviour in prison
- (5) external support
- (6) assessment of suitability for release
- (7) any other comments
- (8) assessment for Grendon.

Furthermore, he showed me a memorandum from the "Lifer Liaison Officer" which indicated: "any reports submitted which do not comply with the standard format as indicated in Annexe C will