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System of Postgraduate Training

SIR,—The need for a new system of postgraduate training is by now self evident. Correspondence has revealed dissatisfaction with some of the changes proposed by the Todd report,[1] and it is important that alternatives should be seriously considered. It is reasonable that a specialist in training should obtain security within five to six years of qualification. It would be most unreasonable to expect the same degree of experience and competence which could be obtained from the current average of 10 years' postgraduate training before achieving consultant status. Although careful planning of postgraduate training in specialties will reduce this difference, it seems inevitable that a new grade of junior consultant will have to be introduced if standards are not to suffer. A possible system of postgraduate training in a clinical specialty which could serve as a basis for discussion is as follows:

Qualification; pre-registration year (rotating internship); specialist training (in two parts lasting five years).

Part 1.—General specialist training—that is, outside chosen specialty, with a six-months minimum in any special department. At least two departments must be included.

Part 2.—Specialist training of three continuous years in own specialty; of this, either two years would be in teaching hospitals and one year in district general hospital, or one year in a teaching hospital, and two years district general hospital.

This and equivalent diploma leads to a junior consultant appointment, which is in some ways similar to senior registrar, but the holder has full security of tenure within the region; does not hold beds in his own right, but is part of a "firm"; may be given full clinical control of patients; does not receive personal income from private patients. A salary in the range £3,500-£4,500 at present values is suggested.

A senior consultant would be one who has beds and may undertake part-time private practice on a sessional basis if he wishes. A salary of £5,000-£6,500 at current values is suggested.

Postgraduate training in limited and highly specialized fields such as neurosurgery or cardiac surgery would best be obtained at the level of junior consultant by attachment to a clinical department. The maintenance of postgraduate examinations is important and serves to avoid the system of patronage implied by some parts of the Todd report. The planning of postgraduate curricula should remain in the hands of the royal colleges but with assistance where appropriate from the universities.

There is no place in this scheme for a widening of the responsibilities of the General Medical Council.—I am, etc.,

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REFERENCE
1 Royal Commission on Medical Education, 1965-8, *Report*, London, H.M.S.O., 1968.

Language of Illness

SIR,—The statement "Diagnostic features of the classical psychoses are little obscured by cultural variations" in your leading article (28 March, p. 768) on the "Language of Illness," needs substantiation. J. E. Cooper,[1] has already called attention to the marked variations in the diagnosis of schizophrenia in two cultures so basically similar as England and America.

Having worked in two cultures, East and West, I find significant differences in the clinical picture of schizophrenia. To take one example in a survey of schizophrenics admitted to hospital in Ceylon we found the incidence of visual hallucinations to be 10%.[2] Visual hallucinations are much rarer in British schizophrenics. This higher incidence of visual hallucinations is probably related to pre-verbal levels of visual thinking in the less literate population, as well as to beliefs in divine and demonic apparitions and visions current in the cultural *milieu*.

Another interesting finding was that when the content of schizophrenic delusions was explored in association with a cultural anthropologist, many of them were found to be compatible with beliefs or superstitions in the patient's community. Thus the labelling of a communication by the patient as being "delusional" was to some extent a measure of the Western (Maudsley Hospital) trained psychiatrist's disbelief, rather than a genuine dissonance between the patient and his cultural community.

It is indeed a curious state of affairs that in two sciences claiming to study human behaviour scientifically we have on the one hand anthropologists who keep demonstrating how different people from different cultures are, and on the other psychiatrists who extrapolate their sometimes meagre clinical material to the conclusion that under the skin all men are psychopathologically the same.—I am, etc.,

L. RATNASABAPATHY.
Stone House Hospital, Dartford, Kent.

REFERENCES
1 Cooper, J. E., *Some Differences Between British and American Schizophrenics*. Maudsley Lecture, 1969.
2 Ratnasabapathy, L., and Jayasundera, M. G., *A Survey of Admissions to Mental Hospital*. Research Report, Ceylon Mental Health Association, 1969.

Depressive Illness in General Practice

SIR,—Dr. A. M. W. Porter is to be congratulated on setting out his findings so lucidly (28 March, p. 773). On the other hand, I think his conclusions may be misleading insofar as the author takes as his terms of reference for depressive illness "a sustained affective illness in which depression of mood is prominent."

Most psychiatrists feel that "depression" is a nosologically inadequate term to describe the variety of clinical patterns presenting in differing personality types in response to stress (whether this is environ-