mental health law because of a complaint by Irish candidates, but clearly the continuation of this policy may well relate to perceived difficulties concerning candidates from other jurisdictions.

Legal provisions are a crucial part of the armamentarium of clinical psychiatry, and it is necessary to overcome practical examination difficulties through examining in alternative jurisdictions. There should be an emphasis on the interface between clinical psychiatry and law, based on the demonstration of adequate knowledge of not only the Mental Health Act 1983 but also common law, including topics beyond civil detention (I am a member of a joint working party of the BMA and Law Society that is writing a book to inform all doctors about a variety of civil legal incapacities). I applaud the college's exploration with the Department of Health of ways of providing training in mental health law both for trainee psychiatrists and as part of continuing professional development for consultants.

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## Locums should have log books

EDITOR,—Clare Dyer's article on a consultant who was found guilty of serious professional misconduct after failing to investigate complaints that a locum, Dr Behrooz Irani, was endangering patients contains a factual error. In February 1993 (that is, six months after the incident at Castle Hill Hospital) Dr Irani was not working in Hull but was employed as a locum consultant anaesthetist at St Lawrence Hospital, Chepstow. The incident in which Dr Irani left the operating theatre to make a telephone call led to an operating department assistant noticing that the patient in whose charge he was left was receiving a hypoxic gas mixture and was beginning to show signs of oxygen desaturation. Fortunately we were using a computerised anaesthetic record system, which captures all physiological and machine data, and we were able to confront Dr Irani with this incontrovertible evidence of his incompetence. Dr Irani was immediately dismissed from his post and was reported to the General Medical Council.

A worrying aspect of this affair is that Dr Irani was able to obtain a post as a locum consultant anaesthetist in Chepstow, having received three good references (two from a previous employer and one from a consultant in Hull) after the events at Castle Hill Hospital in August 1992. I believe that Dr Irani's medical registration should have been suspended pending an inquiry into the incident at Castle Hill Hospital. If he had been required to carry a log book detailing his previous employment and, more particularly, the names of supervising consultant staff we might have been aware of his previous problems before interviewing him for the post in Chepstow.

Locum staff of any grade should be under the supervision of a named senior member of consultant staff in their specialty at the hospitals in which they work. This could be the college clinical tutor or the chairperson of the anaesthetic division. If the names of these supervising doctors were entered into a log book carried by the locum along with the dates of their employment it would be relatively easy for potential employers to trace the locum's activities and previous posts. It has been suggested that such a system would be cumbersome and expensive, but incidents such as that at Castle Hill Hospital are far from isolated and the costs in human misery alone are enormous.

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## Mortality associated with elective caesarean section

EDITOR,—In their analysis of direct maternal deaths reported in the confidential inquiry for 1982-4[1] Lawrence Mascarenhas and colleagues ascribed to vaginal delivery not only the 26 deaths in undelivered women but also the 28 deaths after abortion and ectopic pregnancy.[2] The number of deaths in women delivered vaginally was 40, which gives a direct case fatality rate of 0·02/1000 maternities, compared with that for elective caesarean section of 0·09/1000. The direct mortality associated with elective caesarean section was thus 4·5 times that associated with vaginal delivery in 1982-4.

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## Schizophrenia among residents of hostels for homeless people

EDITOR,—John Geddes and colleagues' study of the prevalence of schizophrenia among residents of hostels for homeless people in 1966 and 1992 is flawed in design, analysis, and interpretation.[1] The authors acknowledge many of these faults in their discussion, but their unwarranted conclusions, specific (even if true) to the situation in Edinburgh, are likely to be misinterpreted by the wider policymaking community. Their findings may well be misrepresented as showing that the problem of severe mental illness among single homeless people is diminishing.

The main design fault derives from the 1992 sampling frame. Only people resident in 1992 in hostels regarded as comparable to those used for the 1966 survey should have been included. The sample in 1992 contained only 72 people (36%) from such comparable hostels. The authors should have presented the characteristics, including the number diagnosed as having schizophrenia, for these 72 people. Though they attempted an adjustment of their 1992 sample, no amount of post hoc adjustment of data can compensate for an underpowered and biased sampling strategy.[2]

We agree with the authors that homelessness is not an inevitable consequence of the policy of community care for mentally ill people, and their interpretation of their results along these lines, if we set aside the question of validity, is acceptable. What is remarkable, however, is that large scale, systematic, and nationally representative research on the possible links between homelessness and the move in Britain towards smaller psychiatric units based in district general hospitals, involving the phasing out of "new long stay" inpatient care, has not been carried out.[3] Until such research is done the findings of numerous cross sectional surveys of single homeless people, including that by Geddes and colleagues, will continue to pose but not answer important questions.[4]

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## Smoking and psoriasis

EDITOR,—Hywel C Williams reviews some of the published work on the link between smoking and psoriasis,[1] but without adequate controls it is not possible to say that smoking could be responsible for up to a quarter of cases of the disease. Most studies have examined smoking in isolation and have failed to consider other confounding variables, particularly alcohol consumption. The only two studies that have taken both factors into account have shown discrepant conclusions: one found smoking to be a greater risk factor than drinking[2] whereas the other concluded that alcohol alone was a risk factor for the development of psoriasis.[3]

In our study smoking was shown not to be an independent risk factor for psoriasis. In contrast, there was a strong association with alcohol consumption: 28% of patients with psoriasis drank to excess.[4] The adjusted risk factor for alcohol in psoriasis was 8·01 (95% confidence interval 3·62 to 17·7). Although the association between heavy drinking and the development of psoriasis is more pronounced in men, it is also relevant in women: 21% of female patients with psoriasis in our survey misused alcohol.

Alcohol thus seems to be more important than smoking in influencing the outcome of psoriasis. Williams emphasises that smoking has little effect on the course of the disease.[1] In contrast, continued drinking is associated with therapeutic failure and abstinence with remission.[5] We are now investigating the possible mechanisms by which alcohol might influence psoriasis. We would reiterate the importance of taking a comprehensive smoking and alcohol history from all patients with psoriasis, both to assess possible aetiological factors and to predict diagnosis.

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