comparable with many Western countries. Health and economic indices which give insight into its present status are listed below.

(a) A literacy rate of 91%, compared with 96% in USA.
(b) Over 90% of people in Kerala own the land on which their home stands. "There are more homeless in the streets of London than in Trivandrum (Kerala's capital city)" (Baird, 1993).
(c) Eighty-five per cent of girls stay at school until age 14 and more than 30% of government jobs are held by women.
(d) Kerala's crude birth rate and infant mortality rate compares favourably with European countries (Black, 1993).
(e) Health awareness and standards are high and most families have access to primary care facilities within walking distance.

Pockets of privation exist in Kerala, as in any country. But the "selective abstraction and over generalisation" which characterise the report makes one wonder whether the authors were interested in research or in sensationalism typical of the "butterfly catching transcultural psychiatrists".

BAIRD, V. (1993) Paradox in paradise; Kerala, India's radical success. *New Internationalist*, **241**, 1–28.
BLACK, J.A. (1993) The population Doomsday forecast: lessons from Kerala. *Journal of the Royal Society of Medicine*, **86**, 704–706.

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Sir: I read the foreign report by the Hacketts (*Psychiatric Bulletin*, 1993, **17**, 752–754) with a sense of *jamais vu*. I have practised psychiatry in a university teaching hospital in Kozhikode (formerly known as Calicut). I could not recognise the place they described.

Kerala is one of the most progressive states in India. It has been hailed as a model for social and economic development for the so-called third world and the poor European nations (Baird, 1993). People in Kerala live longer and the quality of life is comparable with many Western countries (Jeffrey, 1992). Ninety per cent of Kerala's villages have a fair price shop within two kilometres and two thirds of the state's subsidised basic foods go to the poorest 30% (Frankey & Chasin, 1991).

Free primary health care facilities are available within walking distance for the majority of the population (Black, 1993). Of the 3000 psychiatrists in India (population=800 million), about 800 are practising in Kerala (population=30 million). I appreciate that child psychiatry has not achieved the status of a sub-speciality but many psychiatrists take special interest in the psychological care of children. I always believed that the paediatricians and neonatologists in Kerala are doing a good job. An infant mortality rate of 27 per 1000 bears witness to the high standards of paediatric care and nutrition (Black, 1993). The grim picture of a third world country, ridden with dirt, disease and poverty as painted by the Hacketts, is totally inaccurate.

They make a sweeping statement that children of Kerala have to struggle with material deprivation, oppressive regimes of formidable elders and harsh religious indoctrination: they compare them with the "liberally reared, centres of attention children" in Britain. I found this amusing. Having worked in the child psychiatric departments of London and Dublin, I have come across many deprived and neglected children. It will be unpardonable for me to generalise from this experience, like the Hacketts have done. They remind me of the proverbial blind men who ventured to 'see' the elephant: the authors seem to have fumbled upon a patch of pyoderma and did not care to appreciate the magnificent trunk and tusks.

BAIRD, V (1993) Paradox in paradise; Kerala, India's radical success. *New Internationalist*, **241**, 1–28.
BLACK, J.A. (1993) The population Doomsday forecast: lessons from Kerala. *Journal of the Royal Society of Medicine*, **86**, 704–706.
FRANKEY, R.W. & CHASIN, B.H. (1991) *Kerala, Radical Reform as Development in an Indian State*. London: Food First Books.
JEFFERY, R. (1992) *Politics, Women and Wellbeing*. London: Macmillan.

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Sir: Our description of one of the areas where we conducted our epidemiological study into neuropsychiatric disorders in children seems to have touched a nerve. Although Babu & Michael and Mirza berate our account for generalising, it is they who have extrapolated our comments beyond the area from which we randomly selected our 1400 subjects. In doing this they have uncritically quoted state-wide statistics from the colourful magazine *New Internationalist*. These conceal the wide economic diversity of the state. Indeed Calicut District is probably not the poorest in Kerala. Have they ever rolled up their sleeves and conducted a large epidemiological study?

Our differing perceptions may also stem from the fact that they were medical college psychiatrists while we were doing door to door research in the community. Our experience was that many young psychiatrists have seen little of

the living conditions of children in the poorer sections of the community and have little idea of the adversity over which these children triumphed. If they plan to return to India, rather than remain in the West, I will gladly show them the areas where our study was conducted.

Mirza's account of child psychiatry provision is rather misleading. Shortly after we arrived, one excellent psychiatrist started a child guidance clinic in the Government Mental Hospital for one morning per week. This served a district with a population of 2.5 million. His comments on "harsh religious indoctrination" are his, not ours. We felt that the mosque provided an important source of social cohesion that served to protect children from psychological disturbance.

Your correspondents are coy about their own exposure to the community in and around Calicut. In this connection it is worth pointing out that I have spent 31 years (out of 39) living there, so my familiarity with the area is more than just passing. Babu & Michael are wrong to call our study transcultural; it was rigorously conducted using standard epidemiological techniques. Of course, a descriptive account such as our article will involve the selection of material, as any intelligent reader would understand, but we reported only what we saw. What seems to have eluded Babu & Michael and Mirza are the implications of the statistics that they themselves quote. What makes Kerala's achievements in health and education so monumental (our psychologist found 98% literacy by the age of 12) and its reputation as a model of development for the rest of the world so richly deserved, is that it has been achieved in the face of exactly the kind of material deprivation we described in the article. If they have failed to see it, maybe it was because they did not want to.

I am saddened that their approach has been one of hostility rather than interest. As well as conducting a study that would ultimately benefit the local community, our mission during the fieldwork was always to encourage research and critical thought among our local colleagues. I would have been only too happy to discuss our data with them, had they been interested.

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'Passing the buck' – A valid use of Mental Health Review Tribunals?

Sir: Responsible medical officers not infrequently have to make difficult decisions to determine whether patients detained under 'section' are ready for discharge. In particular, uncertainties arise in trying to predict whether patients may pose risks to themselves or others. In our experience, most of these difficulties tend to occur firstly with patients whose problems have a degree of chronicity, a history of serious harm to themselves or others and demonstrate the ambiguities sometimes associated with a classification of psychopathic disorder and secondly, with acutely manic patients (Wilkinson & Sharpe, 1993). Mistaken decisions to discharge have sometimes had tragic consequences which, besides adversely affecting the patient or others, have had direct repercussions on the consultant.

Outcome studies of patients discharged by Mental Health Review Tribunals (MHRTs) are limited in numbers of patients and duration of follow-up (Spencer, 1992; Wilkinson & Sharpe, 1993; McKenzie & Waddington, 1994). Nevertheless, a particular manoeuvre which the responsible medical officer sometimes employs when faced with difficult decisions about discharge is to await the patient's application or reference to a MHRT. If his report is not unfavourable to the patient's discharge, the MHRT may discharge him or her. The consultant will then have averted taking responsibility for the decision. MHRTs are well aware of this phenomenon but their attitudes to it vary. They may see it either as 'buck passing', in which the consultant does not fulfil his or her responsibilities, or as a valid and appropriate tactic in particularly difficult cases where questions of diagnosis or prediction, or both, are uncertain and decisions are made by a small group especially appointed for the purpose and backed by authority. The lack of personal involvement of the medical member in particular will help his objectivity and his intermediate position between the carers and the lawyers can be to the advantage of both. He will bring his clinical experience and skills to bear but most of all will be able to apply a medical mind to a critical review of the evidence and opinions as presented (Langley, 1993).

We should be very interested to hear the opinions of other psychiatrists, particularly members of MHRTs. We feel that, with the increase in adverse publicity and possible litigation resulting from psychiatric miscalculations, the phenomenon we describe may well increase in frequency.

LANGLEY, G.E. (1993) Mental Health Review Tribunals in practice. *Psychiatric Bulletin*, **17**, 331–336.

MCKENZIE, I.P. & WADDINGTON, D. (1994) Mental Health Review Tribunals in Bradford, *Psychiatric Bulletin*, **18**, 55.

SPENCER, D.A. (1992) Follow-up of discharges by Mental Health Review Tribunals. *Psychiatric Bulletin*, **16**, 660–661.

WILKINSON, P. & SHARPE, M. (1993) What happens to patients discharged by Mental Health Review Tribunals? *Psychiatric Bulletin*, **17**, 337–338.

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