

Correspondence

Medical abdicationism

DEAR SIR,

May I be allowed to comment on Dr Walk's letter (*Bulletin*, February 1982, 6, 34). It is an unpalatable fact that doctors have no control on the qualifications and administrative movements of nursing staff. Yes, at the moment medical abdicationism in psychiatry is widespread and has been dictated not by medical failure or laissez-faire but by excessive alteration of relations with other disciplines. The pyramid of decision-making has become so flattened as to be actually *inverted*, i.e., people at the periphery who carry no responsibility have assumed authority. It is strange and absurd that those same people should still critically attribute ultimate responsibility and accountability to the consultant.

I have no nostalgia for the medical superintendent regime. We have *painfully* enriched our experience and considerably helped our patients by coming down to earth, but there is a limit beyond which the concepts 'doctor', 'patient', 'nurse', 'treatment' cannot be stretched.

Perhaps, *change* has gone too far on its own momentum and one can only hope that a series of publicized absurdities and contradictions, such as the one in Dr Walk's letter, will help the inverted pyramid to rebound.

VICTOR S. NEHAMA

Prestwich Hospital
Manchester

Treating the Troublesome

DEAR SIR

I wonder if you would allow me a comment or two on Dr John Hamilton's review (*Bulletin*, March 1982, 6, 47). From what Dr Hamilton says it is obvious that the term 'patient's advocate' has come to symbolize some kind of anti-medicine, as though patients' advocates would be opposed to good medical care. Yet this is not the case. The concept originates in ordinary medical practice. If a patient is advised to have, say, an operation he needs both medical and personal advice before coming to lay judgment whether to accept that advice or not. In this century strenuous attempts have been made in Britain to bring psychiatric treatment as close to this model as possible and even compulsory care under the Mental Health Act incorporates a lay element—either the closest relative or a social worker.

What is being suggested in *Treating the Troublesome*¹ is that these principles should be brought into the second stage of compulsory care if necessary. Some patients already in hospital under compulsion may, in their doctor's opinion, require compulsory treatment as well, perhaps medication or

ECT. *Treating the Troublesome* suggests that it ought to be accepted that in these circumstances it is good medical practice (other than in cases of emergency) to get other medical opinion and discuss the matter with the patient's relatives, friends or advisers, before proceeding with the compulsory treatment. However, the pamphlet specifically sets its face against changes in the law to compel doctors to practise this way, it goes so far as to say 'the best long-term guarantee of . . . safeguards lies in confiding them to independent members of independent health professions, neither individually nor collectively subject to direction (or, as far as possible, even influence) by potentially authoritarian state institutions, and reinforced by professional ethics, and ultimately by the law'. The law it refers to is the current civil law. In other words the pamphlet is advocating a conservative and educational approach to this problem within the legal framework which already exists.

It is impossible in a short letter to discuss the reasons why all of us, doctors, lawyers, philosophers, and lay people, on the CSS Working Party approved of the lay element in all medical decisions, including compulsory ones (even though we felt the current law to be perfectly adequate in this respect) but if anybody is interested in a lucid analysis of the arguments I would recommend Dr Raanan Gillon's John Locke Lecture published in the Christmas edition of the *BMJ*.²

JOHN GUNN

Institute of Psychiatry
London SE5

REFERENCES

- ¹COUNCIL FOR SCIENCE AND SOCIETY (1981) *Treating the Troublesome*. London: CSS.
- ²GILLON, R. (1981) The function of criticism. *British Medical Journal*, 283, 1633–39.

Mental Health Act Commission

DEAR SIR,

May I offer some criticisms relating to the Mental Health Act Commission proposed in the Bill now before Parliament.

The remit of the MHAC may be construed to relate only to individuals. The MHAC is concerned with detained patients and it is envisaged that it will not examine the general conditions in hospital; this task will continue to be dealt with by the Health Advisory Service and National Development Teams. Yet many issues which have a crucial effect on the experience of patients relate to hospital conditions and regulations, and do not lend themselves to consideration from an individualistic perspective. The total separation of the Health Advisory Service and the National Development Teams from the MHAC appears artificial and inimical to the overall raising of standards in the interests of

individuals. It is suggested, therefore, that there should be some harmonization of functions of the MHAC with other monitoring bodies. The remit of the MHAC also does not extend to informal patients. The fundamental objective of the Commission is to protect the most vulnerable sections of the hospital population. Successive inquiries have shown that neglect and impoverished opportunity occur as much, if not more, in the case of informal patients; an important aspect of the College's original proposals was that the Commission should apply to informal patients.

The duties of the MHAC are extensive, including visiting patients, investigating complaints and examining the papers relating to compulsory admission and renewal of detention. In particular, it is envisaged that there will be one or two visits a year to each detained patient in the 300 plus local hospitals and mental nursing homes in England and Wales, with approximately one visit a month to the four Special Hospitals. Yet the Commission will comprise nationally only 70 part-time members, with a small back-up staff. It is difficult to conceive, therefore, that the Commission will have the manpower and resources to serve as an effective safeguard, to develop coherent policies and a thoroughgoing complaints machinery.

Despite the extensive duties of the MHAC, it has not been given any power to effectively carry out its responsibilities. Unlike the Mental Welfare Commission in Scotland or the old Board of Control in England and Wales, it does not have the power to discharge patients who may have been unlawfully detained. The Mental Health Act Commission also does not have the power to enforce its directives, for example, after it investigates a complaint. In sum, the Commission's wide-ranging remit is in sharp contrast with the absence of any powers.

LARRY GOSTIN

MIND

22 Harley Street, London

Community psychiatry

DEAR SIR

If community psychiatry exists as a genuine subspecialty, it is surely not asking too much of Dr Greenwood (*Bulletin*, January 1982, 6, 6–8) to describe clearly and succinctly its clinical boundaries and special functions. As it is, she gives us verbiage and clichés. Small wonder that the College Working Party has failed to agree on a definition of community psychiatry.

Although few people would dispute the figure she quotes of 250 per thousand for the 'prevalence of psychiatric disorder in the general population', many would split hairs and substitute psychoneurotic and psychosomatic for psychiatric disorders. She is concerned that so few of these potential clients are referred to the psychiatric services, that the vast majority are left to the fumbings of their general practitioners, or to their own devices and sufferings. However, all this can be transmogrified, she tells us, simply by 'reaching them'; in her own words, by facilitating a communication . . .

'between a variety of primary care agencies'. This sounds, to say the least, euphemistic. But even supposing she makes contact with these hitherto hidden masses, has she a clear idea of why she wants to do so and of what she hopes to achieve? Surely there is no evidence that psychiatrists are able, by their special skills, to help more than a tiny proportion of psychosomatic and neurotic patients to better health. Frequently these are treated more successfully by their own general practitioners, or non-psychiatric specialists. It is hardly a secret that the clientele of virtually every specialty includes patients whose problems are predominantly psychiatric; yet only those whose behaviour is particularly irritating or upsetting to the doctor, or who are clearly depressed or mad, are referred for psychiatric advice and treatment. This is not primarily because of anti-psychiatry sentiment, but for the simple reason that there is, justifiably, little faith in psychiatric efficacy. In addition, many neurotic disorders fluctuate, fade and disappear spontaneously, whatever is done or not done. Assuming that Dr Greenwood acknowledges all this, does she have some secret therapeutic weapon, or is she simply, as I suspect, engaged on a messianic mission?

This suspicion grows all the greater when one learns that Dr Greenwood actually believes that a community psychiatrist can improve the mental health of a community by 'working with teachers or pupils', especially 'in social and psychosexual areas'. Is this not marvellously idealistic and unrealistic? Does she hope to prevent delinquency, drug taking, vandalism, unwanted pregnancies by her talk? Does she hope to create good, responsible, sexually satisfied citizens of them all through her advisory activities? There is not a shred of real evidence that talks and warnings by psychiatrists or paramedical personnel make any significant difference to adolescent behaviour. And why should they? Why on earth should schoolchildren take any note of what psychiatrists say or write? Why should they, or their teachers and parents, regard psychiatric opinion and pontification as any better or more important than advice from the minister or the Chief Girl Guide, or Mrs Woodhouse?

Dr Greenwood's community psychiatrist is obviously a very hard-working animal. But psychiatrists need to be more than simple, hard-working do-gooders. They must know what they are about, what they are really hoping to achieve, and why. It will just not do to continue to lead our trainee psychiatrists up the garden path. They need to think and to understand, in the fullest sense, what they are about. Community psychiatry does not seem to offer any help to them in this respect.

PETER DALLY

*Westminster Hospital
London SW1*

[We asked Dr Greenwood to reply to the letters from Dr Dally (above) and Dr Corser (March, p 46)—Eds.]