Correspondence

The Mental Health Act Commission and second opinions

DEAR SIRS

I hope I might be allowed to make some comments on Lord Colville's observations (*Bulletin*, January 1985, **9**, 2–3). In this Unit we fully realize that we have to accept the Commission, and our concern is not so much with the principle of having such a Commission, it is the way that surveillance of clinical work is being carried out, especially with regard to psychosurgery.

When considering the role of Medical Commissioners in accepting or refusing our decision that psychosurgery should be carried out for a given patient, Lord Colville writes that 'the statutory second opinion . . . is not one whereby the appointed doctor supplants with his own clinical preference the treatment favoured by the RMO' (p. 2). Again: 'The second opinion is not imposed on him . . .' (p. 3). How do we reconcile these statements with the cases of the two patients who were refused psychosurgery by Medical Commissioners when we had agreed to accept the patients for operation? Do these statements allow us to proceed with psychosurgery in these circumstances, despite the disagreement of the Medical Commissioner?

It is now widely known that one of the patients whose operation was vetoed subsequently died by suicide. Lord Colville seems to dismiss this tragedy in a remarkable way, merely describing it as 'an emotive matter'. Is that really all it is? Indeed, he goes on, 'The danger [of suicidal risk] must not affect and has not affected in the past the application of a bona fide professional judgement'. Is he actually asserting that psychiatrists should not take into account, and never have taken into account, risks of suicide? Lord Colville (p. 2) mentions my reference to a 'legalistic attitude'—these attitudes to suicide strike me very much as being legalistic, and also unsympathetic.

Lord Colville seems to lack an understanding of the second opinion in medicine. This aspect is our main complaint about the working of the Commission. Lord Colville seems to imply that second opinions are helpful on the basis that the opinion of two doctors is better than one. He may not know that the seeking of a second opinion is a very special form of medical communication. The doctor requiring a second assessment of the case will consider very carefully which particular colleague has the appropriate experience and which he most respects in relation to this experience. It is essential for the referring doctor to have reasonable freedom of choice as to whom he will refer his patient. But this is not available with the Commission.

The consultants referring patients to us are presumably reassured by our experience of 1,200 operations. We then have to explain to the patient that another doctor, who is a member of the Commission, has to give his agreement. The patients and relatives ask what is special about this second opinion and what experience of psychosurgery has this Commissioner. For example, one of the doctors seeing our patients is a consultant with an interest in psychogeriatrics.

In these circumstances we will now have to quote Lord Colville who states that: 'Nor am I prepared to comment on the professional skills of anyone called upon to give a second opinion . . .' Thus, our patients must by law be interviewed by Medical Commissioners and two other Commissioners, the patients will not be told whether there is anything special about the clinical experience of the Medical Commissioners dealing with Section 57, yet nonetheless the decision of these doctors is final and there is no appeal. I would, again, describe this sorry state of affairs as intolerably 'legalistic'. Surely the Act does not require this autocratic implementation?

Lord Colville shows touching faith when he writes, 'I find it hard to accept that with all the advice available to him the Secretary of State was so inept in his appointments; that he chose doctor Commissioners not one of whom is fit to carry out the task imposed by the Act, even in psychosurgical cases . . .' Observing the effects on patients of politics and the law becoming over-involved with clinical psychiatry, I find it remarkably easy to accept.

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Provisions for a consultant only service

DEAR SIRS

In her open letter to the President (*Bulletin*, February 1985, **9**, 34), Dr J. A. Hollyman, Chairman of the Collegiate Trainees' Committee, concludes it would seem inevitable that in future a proportion of consultants will have to work without the support of trainees; that all training schemes should incorporate posts outside teaching centres; and that it would seem logical to introduce this model of service during training.

If psychiatrists are to be trained for a consultants only service, the College should make sure it will not create two classes of psychiatrists, but two equal and equally attractive career structures. Today the same psychiatrist can hardly be both an excellent therapist and a competent academician.

If a consultants only service is to attract competent candidates it must be accredited for training the future service consultant and therapist. Facilities should be available for research in patient care (the DHSS would be expected to support such research). Finally, resources comparable to those given to academic services should be available, including laboratory facilities, multidisciplinary and community support and adequate local libraries.

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