

argued that this use of "excellence" was to be found at the opposite end of a dimension from relevance. What the rural team needed (and they had been saying so out loud since 1980) was some more team members. A few players from a team of international excellence (say Liverpool) could, if they played for a less excellent team (say Hartlepool), be a great help to the team and their supporters.

It is regrettable that this political psychiatric grandstanding team has continued into 1989.

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Coroner – A change in practice?

DEAR SIRS

I gave evidence at the inquest of GD yesterday. I expected my role to be fairly straightforward as it seemed to me a clearer case of suicide than usual. Admittedly, I had not seen him for two years but then he, after admission, had been so self destructive in the ward (an unusual happening these days), that he had a special nurse assigned for three days. An unknown patient, after being quiet and withdrawn for a month, he became acutely ill on the day of emergency admission when he thought he had to die. He had heard the Death March being played for him. He had a compulsion to kill himself and this persisted in the ward. He left the ward much improved but a little earlier than we would have wished and declined day hospital or out-patient care because he was moving to Manchester.

Two years later, after he had been abroad a lot, his doctor was suddenly called because he was beginning to get ill again. The doctor's assessment was that an urgent DV the following day would suffice. In the middle of the night he mutilated himself so extensively and badly with a razor blade that he was exsanguinated. At the last moment he did knock on his mother's door and asked her to call an ambulance.

The Coroner accepted that it was his intention to die (not just to do grievous bodily harm). He asked

me, "Had he used the razor blade on somebody else and killed them, would it be your opinion that was of unsound mind?" I answered that "if he had been charged with murder it would be my opinion that he would be saved by the McNaughton Rules".

The Coroner then proceeded in his summing up to say that he was satisfied that the man intended to take his life but he was bound by a judgment of Lord Justice Devlin in implying that a man of unsound mind could neither formulate the intent to murder nor to take his own life, and he returned a verdict of undetermined death.

I had words with the Coroner, whom I know well, afterwards, and suggested that if the case went to appeal his verdict would be overturned. He went on to inform me that he and many Coroners were now recording a large number of undetermined verdicts (he suggested that they now exceeded, in his domain, the verdict of suicide) and he agreed that this was all very unfortunate as it would so distort suicide statistics. This is of importance if it is happening nationally; until now, in this country, suicide statistics had been one of the few hard data facts in psychiatry.

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Changes in the use of the Mental Health Act 1983 four years from its inception in Leeds Eastern Health Authority

DEAR SIRS

As a junior I was recommended the following guidelines, hopefully indicative of good practice within the spirit rather than the letter of the new Act.

1. *Emergency powers* should be used only for instances of dire necessity since there is no right of appeal and no treatment without consent. Such powers terminated by the second doctor should be a small proportion of the total, and should never be left to expire at 72 hours without the patient having had the benefit of a second medical opinion.

2. *Duration of detention* – the RMO should rescind the Section at the earliest opportunity rather than allowing it to expire. Having become informal, it would seem prudent to encourage the patient to remain in hospital before discharge to assess compliance and foster relationships not based on compulsion.

5. *Section 3* – powers lasting less than 28 days should be few.

To assess use of the Act in these areas at its inception and four years later, one hundred periods of detention from November 1983 were compared with another hundred from July 1987.

There were no associations between length of Section and identity of RMO, or length of Section and male or female sex.

Forty-eight detentions in the first group falling to 27 in the second included emergency powers; 14 and 11 respectively remained unconverted, 7 and 5 owing to expiry. A trend towards more Section 3s approached statistical significance ($P=0.103$).

During the first study period 55 patients stayed on voluntarily, this fell to 40 in the second period. Three-quarters of rescinded Section 3 patients were discharged the same day. Twenty per cent of Section 3s lasted less than 28 days in the first period and this rose to 36% in the second.

Approximately half the Section 2s in both groups expired. Just over half of all Section 2 patients remained in hospital voluntarily, most after their Section expired. Thirteen per cent of the first group of Section 2s lasted less than one week; this fell to 8% in the second group.

During both periods there was a trend ($P<0.09$) for females versus males to remain in hospital voluntarily.

On the results of this small survey, rates of use of emergency powers and very short Section 2s showed some improvement; other aspects of practice remained unchanged or conformed less to the guidelines.

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The role of the consultant in mental handicap

DEAR SIRS

The papers and letters regarding the role and responsibility of consultants in mental handicap in the *Psychiatric Bulletin* seem to be never-ending and another one would not make matters worse, hence this letter. I must declare that I am not at all against ongoing appraisal of one's role and responsibility; in fact I consider it to be healthy. Nevertheless, one can be forgiven for asking a few basic questions. Why have there been so many papers and letters? Is there a need for them? Has any other sub-speciality in psychiatry merited such a discussion, and if not, why not.

One of the reasons must be that it is not only those of us practising in this speciality who do not have a definite view about our role and function but other specialists in psychiatry do not either. While some of us feel strongly that we should confine ourselves to psychiatry of the mentally handicapped, others see us having a much wider role, including the traditional work in a hospital; some are content to deal with adults, leaving the children to child psychiatrists and

paediatricians. Perhaps a case could be made for behaviour problems with or without criminality to be dealt with by forensic psychiatrists, physical problems by GPs and physicians, and problems of old age by psychogeriatricians. If this happens, one wonders what the consultant in mental handicap would be left to do. If other professionals and managers follow suit, surely they can be forgiven. In fact I well remember a manager at a conference organised last year by the College's Section of Psychiatry of Mental Handicap, who openly said, "What you consultants should be dealing with is just a few cases of mental illness, a few behavioural problems and some Section cases".

Mental handicap appears to be the field where everybody is an expert, and where it is questioned whether the expertise of psychiatrists is needed, perhaps with some justification.

Another reason put forward is that we are practising at a time of change from hospital care to community care, and we must adapt our role accordingly. The fact that hospital care will continue, albeit on a much reduced scale, is not properly considered, neither is the fact that it will take time before the last of the present hospital population is found alternative placement.

The multidisciplinary context in which psychiatrists in general, and those of us practising mental handicap in particular, find ourselves must be another factor. Why cannot psychologists, social workers, educationalists, nurses and so on work on their own, taking on more and more responsibility and authority, and deal with referrals direct rather than with the knowledge and approval of consultants in mental handicap? Why cannot Community Medical Officers deal with them also?

Questions about the role of consultants in mental handicap have been asked since Mrs Barbara Castle, then Secretary of State for Health and Social Services, produced her White Paper in 1975; among her proposals was one to probe the role of consultants in mental handicap. As a consequence, this matter was discussed at the Mental Deficiency Section meeting (as it was then called) of the Royal College of Psychiatrists in 1976/1977, and a paper was published in the *Bulletin* on 'The Responsibilities of Consultants in Psychiatry within the National Health Service' in September 1977. The responsibilities were under 14 items, and included those of clinician (specialist), co-ordinator, leader, adviser, arbiter, and provider of services. We are aware that the consultant cannot be all these at the same time and that he has a different role in different areas, even within the NHS. His role is primarily that of a clinician (specialist) and adviser with regard to those in Social Services and Education, for example. Yet the discussion continues.

We are frequently being asked to define our workload more precisely. We are criticised for taking on