favourably, on choice, against medically trained analysts.

Senior registrars will need to address a difficult balance: College (JCHPT) guidelines, which fit comfortably lucrative private practice; the needs of varied and sizeable catchment populations; the economic pressure of the developing "market" in health care. There can be few medical psychotherapists who are not afflicted by, or witnessing paranoid anxieties, in these uncertain times.

The medical psychotherapeutic community and its potential clientele have two reasons for thanking Dr Ryle (*Psychiatric Bulletin*, January 1992, **16**, 30–32); for his good sense in the *Bulletin* and for having elucidated cognitive analytic therapy, which can serve as a realistic bridge between ideology and reality. I wish Dr Caldicott and her committee every success in their deliberations on these vitally important matters.

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Leeds Health Authority and
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Psychiatric services for old people in the UK and Australia

Dear Sirs

Professor Andrews' response to Dr Snowdon and myself (*Psychiatric Bulletin*, January 1992, **16**, 48–49) that "the elderly themselves are suspicious of mental health services, fearing institutionalisation in a mental hospital. They *therefore* (my italics) seek mental health care from general practitioners and geriatricians". There is no factual foundation for this statement. Having recently visited services in Australia, I believe that older patients do not seek help from psychiatrists primarily because it is often not available.

I disagree that there are no means to decide whether predominant Australian or British models are best. Studies comparing specialised and non-specialised services in Britain (Wattis, 1989) generally show specialist old age psychiatry services to be better. Also, I have listened to grumbles of Australian geriatricians about psychiatrists' unwillingness to be involved with elderly patients. There are also areas of Australia where psychogeriatric services have developed and these could be compared with areas where such services are not available.

Finally, there are two fallacies in Professor Andrews' final sentence. Firstly, even if nursing home care is cheaper *per person* it is not cheaper *overall* if a substantially larger proportion of the elderly population is placed in such care. Secondly, good specialist psychogeriatric services have potentially cost saving functions (e.g. identifying and treating depressive illness in the community, so avoiding nursing home care) and are not necessarily associated with placement of patients in long-stay mental hospital care.

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Reference

Wattis, J. (1989) A comparison of "specialised" and "non-specialised" psychiatric services for old people in the United Kingdom. *International Journal of Geriatric Psychiatry*, **4**, 59–62.

Managing a challenging case

Dear Sirs

I was intrigued by Drs Joyce and Palia's correspondence inviting suggestions on management for their challenging case (*Psychiatric Bulletin*, January 1992, **16**, 52).

Though brief, the history reveals a married 68-year-old woman (S.T.) who presumably has a family. She has had frequent admissions to the same hospital over a period of 34 years, which suggests that she has repeatedly entrusted her care to the medical staff who in turn have developed a working relationship addressing her needs. Her current diagnosis is unclear. She appears to have chronic schizophrenia with depressive features now prominent. I am unsure whether her lack of insight refers to the ongoing schizophrenia or the more recent depression. Her cognitive functioning is impaired which may be due to the depression, the presence of an early dementing process or environmental factors. She is obviously not capable of independent living, being resident on a long stay ward. The presence of a bladder calculus exposes her to repeated urinary tract infections, leaves her anaemic and on analgesic medication. Anti-cholinergic side-effects of her psychiatric medications pose future risks to her in addition to the more obvious consequences of leaving the calculus *in situ*.

Central to the authors' dilemma is the conflict between the autonomy of their patient and their duty of care to her. If they follow a paternalistic line, should they consider S.T. to be competent but misguided and therefore arrange the operation because its in her best interests? Or should they consider S.T. as incompetent by virtue of the fact that she is making an illogical decision in refusing the operation? Either of the above choices leaves them running the risk of being held guilty of trespass to the person, but equally if they withhold that treatment, they may be in breach of a duty of care owed to S.T.

In S.T.'s case the interpretation of her wishes is uncertain, considering her history, current mental state and her physical health. A judgement has to be made on her behalf and despite her wishes being clear, I feel it is appropriate to do so. S.T. appears to

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