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Adequate provision of study leave

DEAR SIRS

I commend Dr Lucas and the CTC (*Psychiatric Bulletin,* August 1990, **14,** 501) for drawing the College's attention to the problems of trainees in obtaining study leave. This, however, is not just a matter for the College. Dr Lucas neglects to mention the Regional Study Leave Committees to whom juniors can appeal if their leave applications are rejected by district committees.

The regional committee will assess the application on the basis of regional guidelines and can direct districts to grant leave that has previously been refused. Appeals will usually be considered retrospectively.

As a junior representative on the SE Thames Regional Study Leave Committee it is my impression that the appeals procedure is underused not just by trainee psychiatrists but by all specialities and should be more widely publicised. That committee does not regard exceeding an arbitrary financial limit adequate grounds for refusing study leave that is otherwise appropriate. This is an important mechanism by which juniors can counteract the disturbing trend to cash limit, to which Dr Lucas refers.

I would echo Dr Lucas' call for the College to stress that adequate provision of study leave should be an essential prerequisite if a post is to be approved for training. This will be even more important in the reformed NHS where there will be increasing pressure on study leave budgets and where the role of the Regional Study Leave Committee is uncertain.

I was concerned to read, for example, in the *Guy's Lewisham and Mental Illness Services Application for NHS Trust Status,* in the section titled Junior Staffing Issues (p. 5(6)):

> "We will uphold the Whitley Council terms and conditions of service for pay, leave allowance and other main conditions, though we may need to agree ceilings for certain entitlements, such as funds for study leave. . . ."

This ominous statement suggests that in this Trust study leave for juniors is not a "main condition" and may be an area for economy. If leave allowances are to be capped in the new NHS it is essential that the College ensures that they are capped at a level which allows adequate training opportunities for all trainee psychiatrists.

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Promoting the personal

DEAR SIRS

I welcome the trend in August's *Journal* and *Bulletin* towards articles and reviews that centre on the 'person' of the patient – using the word in a more ordinary way than the 'Californian' or even 'psychotherapeutic' sense!

Two doctors described their own experience of being psychiatric patients – Campbell's *Not Always on the Level,* reviewed by Hugh Freeman, *Journal,* August 1990, **14,** 316–317; and Anon's 'View from the bottom', *Psychiatric Bulletin,* August 1990, **14,** 452–454. (Why do we have to have personal experience of our own medicine before we discover such an essential aspect of our work, even though we always insist such awareness is part of our "normal clinical practice" (Thompson, see below)? It couldn't be that there is a basic fault in modern medical and psychiatric training, could it?)

Two articles showed how the person's viewpoint can inform our work better – *Working with the Person with Schizophrenia: The Treatment Alliance,* by Selzer, Sullivan, Carsky and Terkelsen, New York: New York University Press, 1989, reviewed by Chris Thompson, *Journal,* August 1990, **157,** 309–310; and 'Writing to the patient', *Psychiatric Bulletin,* **14,** 467–469.

This is rich and instructive literature. Since we believe it is about "our normal practice", there should be lots more waiting to be published. Yet such articles are rare in your pages. Audit should eventually help highlight this aspect of our work. And the modern moves to market everything may force us to think of what the "customer wants – though our "customers" are the least likely to find their voice. But are there further ways that you and the College can specifically encourage more work and authors like these? Please.

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Catch-22 and community treatment orders

DEAR SIRS

In his case report (*Psychiatric Bulletin,* July 1990, **14,** 402) Dr Gareth Jones describes the adverse effects of the recent ambulance dispute upon an elderly schizophrenic. He states that:

> "Management in this case was made much more difficult by the manifest failure of the Mental Health Amendment Act 1983 in two crucial areas . . ."

namely the failure to provide for compulsory treatment of physical illness in those unable, through mental handicap or mental illness, to give valid consent: and the failure to introduce a community treatment order.

It is far from clear that these omissions do represent failures, either in this case or more generally. There exist well-founded common law powers to treat physical illness without consent in emergencies, and these apply no less to the mentally ill than to anyone else. As Dr Jones reports of his patient "her condition was thought to be neither urgent nor life threatening" and so she was not treated until she provided consent some two weeks later, without apparent ill effects from the delay.

As to the issue of compulsory preventive treatment of mental illness at home, it is not clear how this might have applied to Dr Jones' patient. Would she have been subject to such an order at the outset, before any problem arose? If so, for how long might such an order remain valid – the rest of her life? By what criteria would it be invoked or rescinded? What is the sanction? At what stage in this case would the sanction have been invoked? Or perhaps the order might be applied at the earliest signs of decompensation; in which case it would not be a preventive measure at all, but a therapeutic measure instituted at an earlier stage than Section 3 and presumably by way of looser criteria.

In this regard Dr Jones appears to present an inverted version of Joseph Heller's *Catch-22*, stating, "A refusal to accept such treatment is often symptomatic of various psychoses", and therefore, one presumes, *prima facie* evidence *in and of itself* that the patient is ill and treatment is required. In Dr Jones' view, the patient is only acting rationally as long as she accepts treatment: as soon as she refuses medication, she is no longer acting rationally, and she would have to accept medication whether she consented or not.

Compare Heller:

> "There was only one catch and that was Catch-22, which specified that a concern for one's own safety in the face of dangers that were real and immediate was the process of a rational mind. Orr was crazy and could be grounded. All he had to do was ask: and as soon as he did, he would no longer be crazy and would have to fly more missions."

Legislation to permit enforced treatment of physical illness and to introduce a community treatment order, while no doubt motivated by a paternalistic desire to benefit the patient, threatens to erode the already limited self-determination of the psychiatric patient so much as to make it unacceptable. We must not base our law on anecdotal accounts of poor outcomes in a few cases.

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Reference

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Dear Sirs

Dr Potts raises an interesting and perhaps rather philosophical point.

The primary problem with both general medical and psychiatric care of the mentally disordered who are unable, or unwilling, to give consent, is the difficulty in foreseeing the future.

In particular, my patient had a severely damaged left hand, but the consultant surgeon thought that the condition was neither urgent nor life-threatening. This statement pre-supposes that the condition would only deteriorate slowly, so that emergency treatment could be given if it then became necessary. In practice, the patient could have developed a serious infection, and could well have died of an over-whelming sepsis before any such decision could have been made.

Exactly the same argument can be applied to the community treatment of mental disorder. One might reasonably say that schizophrenia continues as an active condition despite treatment with maintenance neuroleptics, and that the refusal of treatment is a symptom of the continuing activity of the schizophrenia. Here again, the future is unpredictable, and in particular my patient severely mutilated herself though this could not have been foreseen from the previous 25 year history of paranoid schizophrenia.

The Mental Health Amendment Act, 1983, contains many humane provisions, including the necessity for independent medical opinions at each stage of compulsory treatment. I would suggest that what we need is a similar system to cover the compulsory medical and surgical treatment of mentally disordered patients who need such care, with countersignatures from an independent physician or surgeon and an independent psychiatrist.

As an extension of this, I would like to see a similar procedure to the existing Section 58 concerning consent under a Guardianship Order, which I believe, would provide a simple and fairer way of maintaining patients' health despite their suffering from a disorder that impairs their ability to understand the seriousness of risks and complications.

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