# Correspondence

## *Interpreting the Mental Health Act*

DEAR SIR

I am sure there will be much discussion in the future regarding Section 5 (3) of the Mental Health Act 1983 and its interpretation.

Our Division of Psychiatry for Wigan Health Authority has decided that the deputy of the responsible medical officer will be the duty SHO or registrar, and the Regional Legal Adviser of the North Western Regional Health Authority has replied to the District, pointing out that: 'the method outlined seems to comply with the letter of Section 5 (3) of the Act of 1983 . . .'

I feel that I should explain the reasons why the psychiatric doctor on call should be the deputy of the responsible medical officer, and not another consultant, an associate specialist or a registrar with Membership, as some Mental Health Act Commissions might suggest. I am sure their suggestions will be easy to apply in big hospitals and university departments, but most of the psychiatric services in this country are provided by peripheral general hospitals with psychiatric units attached to them, and there are only consultant psychiatrists running them with help from SHOs and one or two registrars (if they are lucky enough to have two registrars). Even if they have got a registrar who has obtained his/her Membership, the next thing they do is to move to university departments.

The only person who is constantly in the hospital is the doctor on call. Administrators come and go, nurses come and go, consultants come and go, but the duty medical officer is available for 24 hours.

Quite often it is difficult to find the consultant on call urgently because most consultants in peripheral hospitals are doing a great deal of domiciliary work.

Suggesting that the deputy should be another consultant is actually suggesting that two consultants should be on call. Some psychiatric units only have two consultants. As a result, problems will appear when one of them is on holiday or off sick.

However, the main reason for our Division to suggest that the duty psychiatric SHO or registrar should be the deputy is because they have more experience in psychiatry, compared to the average GP, who, in spite of lack of psychiatric experience, is entitled by law to sign one of the Sections.

We must not forget that most of these cases will be known to the consultants. The doctor on call will be discussing the case with the consultant on call, on the phone, and when in doubt the consultant on call will be coming to see the case personally. Only a fool would not do so.

When nurses have the holding power, when psychiatrically inexperienced GPs have the right to sign Sections, when any inexperienced police constable can, 'remove that person to a place of safety within the meaning of the Section 135', it is, to our way of thinking, unjustifiable not to allow a junior doctor, after discussion with his consultant, to act as his deputy.

In the last meeting of the North West Division of the College, this motion was passed with an overwhelming majority and the Chairman promised to write to the College for its opinion.

I felt that Members of the College should be informed of this important interpretation of Section 5 (3) of the Mental Health Act, 1983, which will spare unnecessary anxiety to patients and nurses.

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DEAR SIR

Now that we seem to have tacitly accepted the erosion of clinical freedom for consultant psychiatrists explicit in the Mental Health Act of 1983, are we also expected to humbly submit to the dissolution of the cherished tenet of 'no power without responsibility', also clearly written in the Act?

The Act states that in certain every-day circumstances the consultant can be forced to refer the case for a second opinion, and that second opinion has the power of veto over the opinion of the responsible medical officer. In those circumstances, should not the College improve its charisma by altering the accepted code of conduct to ensure that the consultant giving the second opinion, when that opinion seriously differs from the first opinion, should be responsible for the treatment of that patient to the latter's satisfaction?

Finally, we arrive at the worm in the apple—it's psychiatrists today, but it's going to be other consultants tomorrow.

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## *Consultant psychiatrists in mental handicap*

DEAR SIR

The fact that Dr Singh's reasonable and moderate letter (*Bulletin*, June 1983, **7**, 110) has stimulated a long reply from Professor Bicknell (*Bulletin*, September 1983, **7**, 168) demonstrates the fact that commitment to community care to the exclusion of all other provisions is becoming more and more widespread. It is high time that someone (even though only a long-retired Consultant in Mental Handicap) commented on Professor Bicknell's letter and pointed out that the Emperor has no clothes on.



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We, as doctors and applied scientists, should have no concern with the *rights* of any group, which is best left to politicians: our concern should be with the needs of our patients and the best way of providing for them. Long clinical experience, both in hospital and in the community, has convinced me that one of the important needs which adult mentally-handicapped have is to be integrated into social groups of their peers where they can play out the multiplicity of social roles that an ordinary individual performs in his normal life. Unfortunately, the mentally-handicapped in the community are deprived of their social needs just because they live in small groups that can give only limited scope to wider social interactions. Being too distinct from the community at large, if only because of their limited abilities, they are incapable of integration with the normal people round them. Their Social Workers and Trainers frequently act as a screen making the isolation even more pronounced. The motivation of normalization theories is fundamentally a denial of handicap and a feeling that if one pretends it is not there, the handicap will go away. I cannot agree with Professor Bicknell that all good work is done in the community, and that only custodial care is obtainable in the hospitals. Good and bad work is possible in either location, and it is the hospitals, and particularly the large hospitals, that can provide a *supportive* environment which can give opportunities to the handicapped to have a much richer social interaction, to function optimally and to lead a happy existence. Also, in the past thirty years a major proportion of advances in knowledge have been made in hospitals.

Enthusiasts tend to be convinced of the correctness of their cause without feeling the need for critical evaluation and validation of their beliefs, but this should not lead to denying to others the right to pursue their own scientific and clinical interests.

However, what Professor Bicknell and I believe are but untested hypotheses, and remain so until some experimental testing of hypotheses are carried out using rigorously scientific methodology. We need a more scientific attitude, and a very considerable amount of research into the social psychiatry of the handicapped, in addition to organic research which Professor Bicknell wishes to hive off to other specialties. It is highly irresponsible to plan to abandon a well-tried form of care without previous pilot studies and stringent evaluation of the results. I am not against community care as a part of the total care needed by the handicapped, but I do feel the present tendency to denigrate hospitals and starve them of all facilities to be most unfortunate, particularly as it denies our patients specialist care and the provision of a tailor-made social environment. Morale has plummeted, and the reason why we cannot attract any young colleagues to mental handicap is just because no young psychiatrist worth his/her salt, is going to enter a dying specialty where he can expect nothing but opprobrium, and where the transfer of organic aspects advocated by Professor Bicknell is bound to reduce clinical and research activities. This is the cause of the difficulties in recruitment, rather than Professor Bicknell's claim that it is the difference between the putative excellence of work in the community and the even more putative stagnation in hospitals.

Community care is not the universal panacea which many hoped it might prove to be. It is very worrying that present trends towards total community care will have the effect of denying the patients much needed treatment and deprive them of the major therapeutic contribution which hospitals can provide.

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*(This correspondence is now closed—Ed.)*

## *Insanity and genius*

DEAR SIR

Dr Kinnell (*Bulletin,* October 1983, **7,** 188) is probably right to doubt that there is no association between genius and insanity. Dryden's assertion that 'great wits are sure to madness near allied' is a sentiment that has equivalents at all times and in all places, and must reflect some sort of truth. However, I feel that the nature of that alliance is more complex than he would have us believe.

The main problem, I feel, is that we do not know what we are talking about. Much of the confusion in the literature on this subject has arisen through the loose usage of terms such as creative, original, imaginative, genius and talent. It is by no means clear that they are in any way equivalent; a psychobiography of Mozart or Proust is not the same thing as a study of high scorers on 'divergent thinking' tests.

Similarly, excellence can manifest itself in many different spheres of life (e.g. artistic, political, scientific), and since the demands and stresses of these various fields are so different, it is possible that high achievement in each is not due to any single quality.

The greatest obstacle to our understanding, however, is probably due to the fact that 'the genius' is a cultural artefact and a social role. Our modern stereotype derives largely from the nineteenth century when 'the artist' was allowed, even expected, to take a marginal stance in respect to the society in which he lived. This has had various effects: it has allied genius with other marginal groups (such as madmen and radicals) so encouraging their identification. It has made the role of genius an attractive alternative for less exalted marginals, and it has fostered bohemian norms of behaviour in creative people—artists, like everyone else, behave as they are expected to. More generally, so far as the observers of creativity are concerned, this formulation of what constitutes genius has led to the development of an aesthetic in which someone may be valued as much for his instability as for his creations—the careers of Tennessee Williams and Jackson Pollock come to mind in this context. This is not