the physical environment. The aim, the ethos, and the values of the service are fundamental and determine whether emotional needs should be recognised and responded to. In a therapeutic corporate culture the service is organised around the need to understand how patients feel. This contrasts with a persecutory culture in which emotional patients are regarded as a nuisance and their feelings as a burden which interferes with the treatment. Such cultures are fuelled by anxiety and staff are motivated by criticism and disapproval. Empathy cannot survive in such conditions.

Abusers have often suffered from abuse and the oppressed can easily turn into the oppressors. This is the danger of a persecutory culture. Staff who work for an organisation that ignores their emotional needs are in danger of being insensitive to their patients' feelings. If the persecuted tend to become persecutors, then the cared for tend to care. Empathy begets empathy. Caring for staff, recognising their emotional needs, valuing and supporting them is the best way to ensure that they listen to and understand their patients.

Managers and clinicians actually have the same goal. They both want a caring service that is efficient and effective. Effectiveness depends upon good clinical practice, efficiency upon sound management, and caring on an understanding of human nature. They must therefore work together to produce a well managed and clinically proficient service that is sensitive to individual need, to create a therapeutic culture in which the emotional needs of managers, clinicians and patients are attended to. Empathy is managed by empathy.

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Prescription charges and recurrent depression

Recently a patient attending my out-patient clinic suffering from recurrent depression, became unwell again. She is normally maintained on a combination of lithium and a tricyclic anti-depressant. She relapsed because she had stopped her medication, claiming that she could not afford the prescription charges. Her insight has never been good, and she receives scant support from her husband, who is in full-time employment earning a low wage. My patient looks after her young children. The family just fail to qualify for help with prescription charges, although they are the typical sort of family described in a recent national survey as being likely to have financial difficulties (Laurance, 1992). It is well established that women in such families have a high rate of depression.

The World Health Organization now advises prophylactic medication for patients with recurrent episodes of unipolar depression. I have certainly found this strategy to be useful. I would have thought that a case could now be made for sufferers of recurrent depression to be made exempt from prescription charges. The Department of Health leaflet P. 11 states that sufferers of diabetes, epilepsy and hypothyroidism (plus others) are entitled to free prescription, presumably because they require medication to remain well as opposed to needing treatment to get better, so why not extend this principle to those who need maintenance psychotropic drugs to keep them euthymic? Perhaps the Royal College of Psychiatrists could take up this issue in its forthcoming campaign to "Beat Depression".

The recently announced increase in prescription charges does not, I fear, improve the immediate prognosis for my patient.

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Professor A. C. P. Sims, President, writes "Thank you for making this useful point; the matter will be discussed further at the Executive and Finance Committee of the College".

Reference

LAURANCE, J. (1992) More families fall into debt. *Times*, 27 February, 3.

Treating physical illness without consent

DEAR SIRS

It is well known that the Mental Health Act does not contain provisions to enable treatment of physical disorders without consent. However, it seems less widely known that it is possible to first detain someone under the MHA, and then under common law treat a physical disorder without consent, if the physical disorder is *caused* by a mental disorder or is itself the *cause* of a mental disorder, and treatment of the physical disorder is considered to be in the best interests of the patient.

One of our patients who suffers from schizophrenia presented with a history and clinical signs consistent with a major head injury. He was unwilling to undergo investigation or treatment and the MHA was used to facilitate doing so. The patient was found to have sustained an extradural haematoma and underwent an emergency craniotomy and drainage.

Although initially detained at the psychiatric hospital under Section 4, the investigation of the physical disorder was carried out under common