this issue. The implications of such a step are clear. The WHO Report and the *Lancet* editorial created international concern about ethical aspects of mental health practice in South Africa. Since the world's attention has been directed to these problems there has been some improvement in the situation (Stone, 1979).

At present the College (and other psychiatric institutions in the UK) has flourishing contacts with South African psychiatry, which only adds to the unease that many feel about the College's silence. Recent events, including the refusal of the South African Medical and Dental Council to proceed against doctors implicated in the death of Steve Biko, and the increasing number of doctors held as political prisoners or who have actually died in custody (Parkes, Ryan *et al*, 1978) only strengthen the argument for the College to make its position clear on the very sensitive issue of mental health and apartheid.

S. P. SASHIDHARAN

Royal Edinburgh Hospital
Morningside Park
Edinburgh EH10 5HF

REFERENCES

DEELEY, P. (1975) In *The Observer*, 22 June.

DE VILLIERS, F. (1975) In *Johannesburg Sunday Times*, 27 April.

EDITORIAL (1977) Apartheid and mental health care. *Lancet, ii*, 491.

GILLIS, L. S. (1977) Mental health care in South Africa. *Lancet, ii*, 920.

JABLENSKY, A. (1978) Mental health care in South Africa. *Lancet, i*, 270.

PARKES, D., RYAN, K. C., *et al* (1978) Medicine and apartheid. *British Medical Journal, i*, 306.

REPORT OF THE COMMITTEE TO VISIT SOUTH AFRICA (1979) *American Journal of Psychiatry*, 136, 1498.

STONE, A. A. (1979) Psychiatry and race in South Africa. *Lancet, ii*, 530.

WÄSTBERG, P. (1976) In *Dagens Nyeter* (Stockholm), 18 and 20 February.

WORLD HEALTH ORGANIZATION (1977) Apartheid and Mental Health Care. A preliminary review by WHO secretariat of the available information on mental health services in the Republic of South Africa, prepared for the United Nations Special Committee Against Apartheid, MNH/77.5.

Approval under Section 28(2)

DEAR SIR

I was interested to read the item on page 141 of the issue of September 1980 in relation to the approval of medical practitioners under Section 28(2) of the Mental Health Act 1959.

The College seems to have taken upon itself the task of interpreting the law. I find these occasional statements from the College are regarded by the profession with the same degree of reverence as the children of Israel regarded the tablets of stone handed down from Mount Sinai, and they tend to have the force and importance of law and are not regarded as mere advice. I am being reminded continually by my juniors as to how I should give ECT and what I can do and not do in relation to compulsory treatment. This latest piece of advice is part of the same series. I feel that College interpretations of the law are not going to be of much advantage to psychiatry, and it surprises me that the College should have taken this on.

The Mental Health Act was drawn up in relation to Section 28 on the basis of very good advice given by senior members of the old RMPA. Many of us had had years of experience of dealing with medical practitioners who were regarded by the local authorities as experts in psychiatry but who had no real training in psychiatry. These doctors spent a large part of their time going around towns certifying patients and sending them into mental hospitals. Very often their attempts at diagnosis were very misleading and inaccurate. At the time the Mental Health Act was passed (DHSS, 1960, Memorandum on Mental Health Act, 1959, pp. 11-12, para. 49), it was made abundantly clear that in the ideal situation the two doctors involved in compulsory procedures should be the patient's own general practitioner and the responsible medical officer who is going to look after the patient in the hospital. This is an ideal which really does its best to safeguard the liberty of the individual. We are departing from this ideal if we are going to condone the recognition under Section 28(2) of numbers of doctors who are neither going to be the patient's general practitioner nor the consultant who is responsible for the patient's treatment.

There is an additional factor that has emerged in recent years. Surprisingly the courts have chosen to recognize Section 28(2) as a distinction of some sort. It is not enough to be a consultant and to be well qualified: one has to be recognized under Section 28(2) as well. Only such a doctor will have his evidence accepted as valid by the average court of law. Only such a doctor is entrusted by the Court with the care of patients under Probation Orders. The College has decided that the criteria for appointment to the Hospital Practitioner grade should be the criteria for approval under Section 28. Basically this is two years full-time hospital experience in a specialty. I have had many juniors during the last 20 years who have spent two years in psychiatry and then decided for various reasons to leave the specialty. I would not consider that the great majority of these had sufficient expertise in psychiatry to merit appointment under Section 28. Again, this Hospital Practitioner grade is a rather doubtful entity. In my current issue of the *BMJ* I can find no advertisement for any appointment in this grade in any specialty. As a result, by default what will happen is that people who have been appointed as clinical assistants will be recommended for approval under Section 28,.

If the College considers that there is a need in certain areas for approval of doctors under Section 28 it can only mean that there is a shortage of consultants in that area. It would be in the best interests of the profession if the College

were to press rather for the appointment of more consultants than to seek ways of diluting consultant responsibility by appointing people to this grade. It would appear that the College has really decided that there is a case for a sub consultant grade of psychiatrist who will carry out the duties of the Mental Health Act under Section 28.

I would have anticipated that such a move might come from community physicians, from heads of departments of Social Services and local authorities, putting pressure on the Department of Health but I do not think it is appropriate for the College to lead in this direction. It is the College's function to maintain high standards of professional practice and to ensure that consultants are appointed in sufficient numbers to carry out their duties under the Mental Health Act.

I would consider further that the College ought to have had wider advice from its membership before making such a recommendation. Indeed, any legislation in relation to mental health is considered by a very wide channel of medical opinion before being put into practice.

JOHN T. HUTCHINSON

Cane Hill Hospital
Surrey, CR3 3YL

Psychiatry for the general practitioner trainee

DEAR SIR

Your special correspondent who reported in the August *Bulletin* on the Joint Conference on Psychiatry for the General Practitioner Trainee has misrepresented me. I did not intend that GP trainees should spend more than six months in psychiatry. I suggested that, as an alternative to a full-time attachment, there might be a longer period of day release when they could work with the same patients over a year or so. Dr Horder takes up the same point in his letter to you. The one-day meeting was most valuable, and I hope that further discussions will take place between the two Colleges leading to closer programme building.

NEIL KESSEL

University Hospital of South Manchester
Manchester M20 8LR

Recruitment to mental deficiency work

DEAR SIR

We refer to the statement on Shortage of Manpower and Poor Recruitment to the Specialty of Mental Deficiency which was published with approval of the Executive and Finance Committee of the College in the April, 1980, edition of the *Bulletin*.

While the statement is laudable in its intent we believe it cannot assist in the medical staffing of mental subnormality services. In particular the section on joint appointments is dispiritingly negative, to say nothing of being gratuitously condescending to the many present holders of these posts in the United Kingdom.

Joint appointments are neither new nor rare. We understand that in the past 10 years more than half of the consultant appointments in mental handicap in Scotland, and a substantial number of those in England and Wales have been on this basis, and we would argue that valuable expertise in child and general psychiatry, as well as in paediatric medicine, which might otherwise have been deployed in other fields, has been recruited to mental handicap in this way. We know of no evidence which suggests that the quality of care given to patients is in any way diminished by the joint nature of these appointments, and we resent statements which imply that it has been.

Joint appointments in Scotland, and we suspect also in England and Wales, have widened the entry point to senior medical staffing in the field of mental deficiency, have helped to bring psychiatric trainees of calibre into the specialty, and have enhanced research.

As the statement of the Executive Committee of the MD Section stands, we think it is more likely to deter than to encourage recruitment of psychiatric and other consultants to the care of the mentally handicapped.

HECTOR C. FOWLIE

Royal Dundee Liff and Strathmartine Hospitals
Dundee

Also signed by: P. G. AUNGLE, W. BAIRD; B. R. BALLINGER; I. R. C. BATCHELOR; J. CHICK; H. DAVIES; R. DRUMMOND; S. FAZLULLA; W. FRASER; M. K. P. HENDERSON; R. I. KENNEDY; A. LODGE; M. MCLEOD; G. J. NAYLOR; M. RENNIE; A. H. REID; B. RITSON; H. ROSS; A. H. W. SMITH; A. ZEALLY.

Treatments in psychiatry—Who decides?

DEAR SIR

In the SK & F publication of the proceedings of a recent APIT meeting (1980), Mr Larry Gostin asserts that there must be 'lay, legal and social assessment' of patients refusing consent to treatment.

In this and the related matter of consent to hospitalization we do not yet know whether some of the changes proposed in the Government White Paper (DHSS, 1978) will be translated into law despite being opposed or rejected by the Royal College (*Bulletin*, 1979). However, it is evident that pressures for these changes persist.

'Lay, legal and social' assessments do in fact take place now in the case of Hospital Orders under Sections 60 and 65 and of the Mental Health Review Tribunals. But the Royal Commission of 1953-7, and Parliament when it passed the 1959 Act, thought it sensible and appropriate that for non-criminal patients a magistrate should not necessarily be