unit, with the two psychiatric hospitals accounting for 30% and 27% respectively; 11.1% of those appealing were of Asian origin. Of those appealing, 44.5% had a diagnosis of paranoid schizophrenia, 39% of manic depressive psychosis, 5.3% organic psychosis, and 2.7% (one patient) anorexia nervosa and depression.

Of the 36 who appealed, only six were released by right of appeal i.e. only 1.5% of those originally admitted. Five of the six were women, contrasting with the previous equal sex incidence, and they tended to be older than the rest of the appealing population (average age 50.2 years). None of the successful appealers were of Asian origin. Four of the six released were from the district general hospital, the other two being from one of the psychiatric hospitals and the other hospital having none released. One interesting finding was in relation to the month of admission. There was a fairly even distribution of admissions throughout the year, but of those who appealed 50% did so in the summer months ($P < 0.005$). Therefore few people were released by right of appeal from a Section 2. We have identified epidemiological factors which merit further attention, seasonal variations, sex ratios, and ethnic factors, but the small number of patients involved makes such work difficult.

One of the hospitals had a very low number of appeals compared to the other two which raises questions as to the whole process of appealing as it exists in different hospitals. A tribunal is expensive in terms of tribunal costs and hidden costs of professional time from different disciplines. Low release rates may reflect: the appropriateness of nearly all admissions, improvement caused by comprehensive treatment, the need to appeal in writing, and that a mechanism other than the 14 day limit is needed to give an opportunity for patients to appeal. Further prospective studies are needed for the evaluation of such factors.

J. O'Dwyer

Psychiatric Department
Leicester General Hospital
Gwendolen Road, Leicester (correspondence)

P. Neville

Carlton Hayes Hospital
Narborough, Leicester

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NHS newspeak

Dear Sirs

Nearly 150 years ago Carlyle wrote:

> "Our life is not a mutual helpfulness; but rather cloaked under due laws-of-war, named 'fair competition' and so forth, it is a mutual hostility. We have profoundly forgotten everywhere that *cash payment* is not the sole relation of human beings . . ."

It is distressing to find these words (from *Past and Present*) so relevant to present day life in the National Health Service. For all my professional life I have enjoyed the fact that mutual respect and dignity and not *cash payment* determined my relationship with my patients. Now, as I approach retirement, I find a chilling alteration in the discourse; accompanying the organisational changes, a shift in language and assumptions ("NHS newspeak") is taking place, serving to conceal or re-define the values embodied in the service.

Given the overwhelming public support for the values incorporated in the National Health Service, one might have expected that the current reorganisation would have been carried out at least in the name of these values, but this has not been the case. Perhaps the extent of the cuts and shortfalls and the almost unanimous professional opposition to the changes proposed were too great a challenge for even the slickest copywriter; patients at the end of long waiting lists reading of successive ward closures can hardly be expected to applaud the idea that "less is more". Whether for this reason or on more general ideological grounds the approach adopted has been one of imposing the language of the supposedly triumphant market on the discussions. It is, of course, the language rather than the reality that has been imported, for few believe that the economic realities of this century can be adequately described in terms of Adam Smith's street market, and the proposed NHS is still an enterprise that has no product to sell, with structures that offer no more than a pretence of competition. Even were one to accept that cash payment should be the "sole relation of human beings", this arrangement would be a shoddy expression of such beliefs. In reality, the health service is neither a street market nor a supermarket; it is an unfortunately costly overhead in the gigantic firm of Thatcherism plc (now itself undergoing a minor reorganisation) and this being so, the aim of management must be to keep the cost down. The rhetoric about the market serves to conceal, or seeks to justify, the policy of consistent under-resourcing of health care, a policy which most people, were it clearly proposed, would oppose.

Nowadays, to talk in terms of health care delivery or of professional standards and requirements brands one at once as an old fogey, whereas mention business plans, ring fencing and income generation,

and one is at once recognised as a *new man*. I had a vivid reminder of this at a recent meeting of consultant psychotherapists called to discuss the impending changes; a colleague showed a transparency of a beleagured psychotherapy service being menaced by two resource-seeking crocodiles labelled 'social workers' and 'psychologists'. I believe it is our patients who are menaced when professional relationships are construed in such terms of "mutual hostility" cloaked under the name of "fair competition".

There is a particular irony in the use of the new language in 1990, the year in which the market has apparently been wholeheartedly embraced by Eastern Europe. In the name of supposedly libertarian market values, a system of management is being created for the National Health Service which will be instantly recognised by those from Eastern Europe: with minimal exposure to public influence or inspection and with a much reduced professional participation, a vertical command structure is being created in which personal advancement for those lower in the hierarchy can only depend upon pleasing those higher up.

The defence of our patients' interests and of our own profession demands exceptional vigilance and I believe the preservation of clear speech is crucial. In making our own proposals, in considering managements plans, and in auditing our own work we must never leave out of what is said and what is recorded the information relating to the point of our enterprise, namely the provision of health care to the people of this country. The quality of care available, the efficiency with which it reaches those in need, the costs in human terms of what is *not* provided and the conditions of work of the professionals providing care should all appear in every evaluation. We are in the business of providing a service, not of serving a business, and our concerns must be expressed in, and defended by, the language appropriate to our professional commitment to that service.

A. RYLE

St Thomas' Hospital
London SE1 7EH

Teaching descriptive psychopathology to medical students

DEAR SIRS

Making psychiatry interesting for medical students is one of our great priorities. It is the only way we can recruit more doctors into the specialty at a time when more and more medical personnel tend to see other areas of practice as more rewarding.

Students tend to find descriptive psychopathology difficult. This is quite understandable. The terminology of psychopathology is not very precise and there are several phenomena which are easily mistaken for something else. The clarification of the concepts of descriptive psychopathology is an on-going assignment for us all.

I have discovered that by asking medical students to "Make a list of the things we do with our minds", and "Against each entry put down your own ideas of the various ways in which the function concerned can become abnormal", a good foundation is laid for the understanding of psychopathology. By the time they have worked through this activity they have, in fact, come up with descriptions of most of the signs and symptoms of mental disorder, even if they do not use the proper terminology.

A couple of tutorials clarifies their thinking about these things, as well as providing or confirming the correct terms for the signs and symptoms they have already figured out and adding those they missed.

I have found that because this exercise challenges the students' initiative and sense of discovery, it is a much more interesting activity for them than lectures on the subject.

IKECHUKWU O. AZUONYE

The Royal London Hospital (St Clement's)
London E3 4LL

Chaos in mind

DEAR SIRS

I would like to comment on the conference report, 'The Atom in Mind' (*Psychiatric Bulletin*, September 1990, **14**, 559).

With the growing interest in the behaviour of dynamic systems in medicine, the reductionalist approach may not be the way forward when addressing the mind-body problem. Pressing the techniques of the individual specialisms of psychology, neurophysiology, theology, physics and mathematics to their limits may result in further division. The study of systems and chaos, although having its origins in mathematics, tends to unify across disciplines.

The brain is a complex dynamic system, with feedback at multiple levels of organisation. It is, however, not isolated but exists in the context of many other systems: the body, the environment, the family, and society. It is within these systems that body image and self-esteem are defined. The mind may therefore exist as a product of multiple dynamic systems, interacting at different scales, creating one whole. There is, however, more than mere complexity of the holistic approach which would be beyond analysis. For example, consider the brain alone: it contains 10^{13}–10^{14} synapses each of which will display non-linear behaviour. Simple dynamic systems, however, containing few non-linear elements can have complex, seemingly stochastic and unpredictable behaviour even though traditionally one would expect deterministic and thus predictable properties. Such

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