On what basis does Nasser bracket Szasz with Cooper and Laing? Szasz has always written from the position of right wing libertarianism whereas Cooper and Laing were on the left wing of politics. Even linking Cooper and Laing in this way is suspect if we take Mullan's (1995) record of conversations with Laing as accurate. Here Laing's promiscuous interest in liberal thinkers contrasts with his portrayal of Cooper as a committee communist activist in exile.

Is there shared thinking between the three? One footnote apart, Szasz makes no mention of Laing or anti-psychiatry until *Insanity: The Idea And Its Consequences* (1987). Here he castigates Laing for claiming to be a doctor of non-illnesses. Laing appears to confirm Szasz's antagonism when reporting one encounter to Mullan (op. cit.). Prior to the Mullan publication Laing and Cooper only mention Szasz in three footnotes.

Arguably Szasz, Cooper, and Laing can be grouped as critics of orthodox psychiatry but can hardly be characterised as sharing any kind of platform.

These comments may be dismissed as debating points, but my main interest is in important questions implicit in Nasser's letter: Is critique of our work always to be experienced paranoically, as the barbarian at the gates? If self-critique by psychiatrists is to be routinely savaged should we dismiss out of hand the considered views of fellow professionals from other disciplines? Should we make the reflex assumption that representatives of MIND are engaged in a relentless moral crusade against all our profession stands for?

BOYERS, R. & ORRILL, R. (1971) *Laing and Anti-Psychiatry*. Harmondsworth: Penguin.
COOPER, D. (1970) *Psychiatry and Anti-Psychiatry*. St. Albans: Paladin.
LAING, R. (1985) *Wisdom, Madness and Folly*. London: Macmillan.
MULLAN, R. (1995) *Mad To Be Normal: Conversations With R. D. Laing*. London: Free Association Books.
SZASZ, T. (1987) *Insanity: The Idea And Its Consequences*. New York: Wiley.

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Sir: I stated that the anti-psychiatric movement grew in the realm of politics, particularly of the left. I did not say however that Szasz belonged to the left. Szasz's political views were seldom made obvious (Sedgwick, 1982). His views were commonly regarded as libertarian, anti-collectivist that focused mainly on the individual. Some saw an inherent contradiction in Szasz's political argument as he appeared more to the right than the prevailing capitalist structure that was the subject of his attack. My inclusion of Szasz with Cooper and Laing was unrelated to his political ideology, more that he belonged to the antipsychiatric movement and his premise was largely in keeping with that of Laing and Cooper.

It is difficult to see that the anti-psychiatric movement only represented a different view point or an *antithesis* that was not hostile to psychiatry. In Cooper's language of madness, he says

> "most victims of supposed madness, suicide are made victims by those who compulsively have to help . . . were it not for the stigmatisation, the institutionalising process, and the interference of doctors who have to justify their existence by the medical game of diagnosis, shocks and chemical euthanasia" (Cooper, 1980).

It is regrettable that the anti-psychiatric movement did not evolve or develop into a real antithesis to provide a much needed alternative view. It has certainly contributed in the past to lively debates about the nature of psychiatry and been probably instrumental in shaping existing psychiatric services.

The new community facilities have to a great extent rendered the psychiatrist physically and intellectually isolated. There is therefore a need to look at the structure of the training of other mental health professionals as well as our own. The point is to not live in the past, entertaining scientifically unfounded beliefs or indeed thinking only in terms of neurotransmitters. What is needed is to encourage the development of a discourse to enable the expression of other views, which are truly vital to the current state of psychiatric practice and its future.

COOPER, D. (1980) *The Language of Madness*. London: Pelican.
SEDGWICK, P. (1982) *Psychopolitics*. London: Pluto Press.

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Leave and detained patients

Sir:

> "Many still believe, incorrectly, that a detained patient may go on leave without the completion of Section 17 leave formalities if they are only going out of the hospital grounds for a short while or if they are escorted by staff."
> "Section 17 applies to the shortest period of absence. . . ."

These quotations from the 6th Biennial Report of the Mental Health Act Commission (MHAC) are perfectly clear – as long as we know what "hospital grounds" are. The term "hospital" is finally, unhelpfully, defined in Section 145, of the 149 Sections, in the 1983 Mental Health Act; grounds are not. "What is a hospital?" asks MHAC Practice Note 3, 1994. The question may

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seem esoteric and perhaps one that should not even be asked when a modern "seamless service" is provided between hospital and community.

Consider a district general hospital (DGH) serving the local community. The advent of Trust status has divided this previously functional unit into three Trusts, each managed separately. Can patients, detained under Section 3 in the psychiatric Trust, no longer visit the hospital canteen opposite, nor the WRVS cafe next door? A visit for morning coffee would have to be preceded by an expensive and time consuming Section 117 aftercare meeting. (Code of Practice, 1993 Chapters 20 and 27).

Consider another DGH some miles along the motorway. This hospital has the same managers as the previously mentioned psychiatric unit so is therefore "the same hospital" (MHAC Practice Note 3, 1994). Is a patient under Section 3, or Section 5 (2), transferring between the widely spread wings of this single hospital, in any way "in the hospital grounds"?

Consider a hospital unit of four wards. Two upstairs wards are part of the psychiatric DGH Trust, two are not. How far down the stairs can a physiotherapist take a Section 3 patient, for mobility exercises? To where do these wards' grounds extend?

Successive Biennial reports issued by the MHAC offer relevant commentaries on current issues and helpful advice. Unfortunately, the dividing and recombining of clinical services, under separate Trusts, complicate service delivery and make implementation of the reports' advice more difficult. We must be clear about where the hospital and its grounds terminate because of increasing accountability and litigation. As Coiera (1996) warns, "While patients may be motivated to seek out the most recent literature for their condition and can invest considerable efforts in that search, most practising doctors cannot".

COIERA, E. (1996) The Internet's challenge to health care provision. *British Medical Journal*, **312**, 3–4.

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The moral status of suicide

Sir: Oyebode's article (*Psychiatric Bulletin*, **20**, 85–89) was both stimulating and interesting. I would like to state some aspects of Buddhist philosophy relating to life, death and suicide. In Buddhist philosophy, referring to Gautama Siddatha and his teachings that go back more than 2500 years, life is sacred not because it was *"God"* who created it. It is sacred because life is the culmination of all the *"right forces"* happening in the *"right manner"* and at the *"right times"*. The other associated notion is of the present life as just one in a series of many. The cause and effect – do good and prosper and do evil and suffer, is somewhat of a theme here. Kill yourself once, leads on to kill yourself again and again in the lives to come. This teaching bears no resemblance to the idea that 'God' is the creator. The 'crime' of taking one's own life is with oneself – nobody else is involved. It is not against the state, humanity or even religion. Life is not an end in itself – it is a means towards the end, Nirvana. The concept that 'one is the master of one's own destiny', appears to have a powerful impact on those who practise Buddhist philosophy.

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Whose journal is it anyway?

Sir: Rather than stacking a journal unread on the shelf, can I remind readers of the possibility of donating journals and books to needy libraries overseas. Book Aid International support mainly African libraries. They are pleased to receive a few years' collection of a journal, or an annual commitment as a delayed subscription. Transport can often be arranged via the local rotary club. The address to contact is: Book Aid International, Tel: 0171 733 3577; Fax: 0171 978 8006; Email: Hs@gn.apc.org.

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