Dr Sidney Levine, in his article on the College's Special Committee on the Political Abuse of Psychiatry (*Bulletin* (1981), **5**, 94), comments that this committee 'deals with the political abuse of psychiatry wherever it occurs'; and that 'treatment in South Africa is not primarily political'. Yet, with a curious dialectic, Levine refers to South Africa and reports that Dr Sidney Bloch visited some hospitals there in 1978 and found conditions unsatisfactory; 'this discriminatory treatment will be kept under continuing review'. Will Dr Levine kindly inform readers: who arranged Dr Bloch's visit; which hospitals did he inspect; what did his report actually say; and was it sent to the South African Mental Health Authorities? How is the 'continuing review' to be achieved—with the co-operation of the South African Government or by further visits of representatives of the Special Committee?

Dr Ryle's observation (*Bulletin* (1981), **5**, 148) that there is 'differentiation of standards of psychiatric care according to skin colour in South Africa' is untrue.

The College's 1981 Annual Report (page 6, paragraph 4) states that 'Council is seeking the views of its members in South Africa about possible effects of apartheid on psychiatric services or the training of psychiatrists.' As this inquiry has been announced out of context, the reader might infer that the College had grounds for suspicions about South African psychiatry. Council had no such grounds, but had been under pressure from an anti-South African lobby to make a pronouncement about it (Sashidharan, 1980). To assist Council to deal with the matter, the Registrar wrote to all members in South Africa who alone had up-to-date personal experience of it, asking for their views and comments.

Fewer than 10 per cent of the approximately 150 psychiatrists in South Africa are members of the College. While their views may be useful for discussions in Council, they are of course not a representative sample of psychiatric opinion in South Africa, and cannot be reported as such.

South African psychiatry has been a target for criticism and innuendo in four publications in eight months. It has been mentioned unjustifiably along with Soviet Russia, Mauritani, Rumania and the Argentine in the context of political abuse of psychiatry. These seem to show a common desire to focus unfavourable attention on South Africa without regard for objectivity or accuracy, or the consequences to professional colleagues.

To summarize:

1. South African Mental Health Legislation neither enacts nor allows discriminatory or political misuse of psychiatry.
2. No South African psychiatrist has ever been asked by the authorities to practise unethically.
3. No psychiatrist in South Africa has ever been accused of unethical practices in this context.
4. According to my enquiries, no complaints of such unethical practices have been received by the College from psychiatrists or patients in South Africa.
5. It should be realized that, with its small membership, the College cannot represent South African psychiatry.
6. Excellent relationships exist between South African and British psychiatrists and South African psychiatry has benefitted from the help and advice of the College and its experts in clinical and scientific fields.

It is regrettable that the College press should have been used for publishing anti-South African letters of a political nature.

R. E. HEMPHILL
(Formerly Medical Superintendent, Barrow Hospital, Bristol)

Department of Psychiatry
Groote Schuur Hospital
Cape Town

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[Members of the College are free to raise questions of general interest and express opinions on their own responsibility, whether or not the Editors happen to agree with them, and whether or not they express an official view. The psychiatric treatment of Blacks in South Africa has become a matter of international interest. We have asked Dr Levine as a member of the Special Committee on the Political Abuse of Psychiatry and author of the article which appeared in the *Bulletin* (1981, **5**, 94-95) to reply to Dr Hemphill's letter—Eds.]

DEAR SIR,

The apartheid policy of the South African Government is universally condemned. My article referred to the carefully documented conclusions of a commission of the American Psychiatric Association in 1978 that this policy resulted in discrimination against non-white patients treated in mental hospitals in South Africa (*American Journal of Psychiatry*, **136**, 1498-1506). While on a private visit to South Africa, Dr Bloch contacted the Smith Mitchell Company which administers a number of psychiatric hospitals in that country and was permitted to visit four of them in the Johannesburg area. He submitted a brief report of his observations to our Committee which was in broad agreement with the APA findings. As a result of this information, our Committee has concluded that discriminatory treatment to the detriment of the black community does occur. Based on this evidence I stated that 'this form of discriminatory treatment is not considered to be primarily political but will be kept under continuing review' (*Bulletin*, 1981, **5**, 95)

Our Committee has so far not received evidence that the South African Government has used psychiatry as a specific weapon for the suppression of dissent, as occurs in the Soviet Union, and it is for this reason that I suggested that the discriminatory practices are not 'primarily political'. However, if an abuse of ethical standards in the practice of psychiatry is occurring as a result of a Government's policies, then it could be cogently argued that our Committee's interpretation of political abuse has been hitherto semantically restrictive and that there is justification in reviewing our remit to consider our reponse to the information we receive about the practice of psychiatry in some South African hospitals.

The continuing review will occur through the receipt of information from interested sources, and Dr Hemphill can be reassured that unsubstantiated allegations would be insufficient. He must also appreciate that unsubstantiated denials are equally unacceptable. He can be further reassured that the College would not restrict its sources of information to our membership in South Africa, although it seems logical for us to sound their views.

Dr Hemphill has requested helpful or constructive suggestions and I suspect that these will be forthcoming from the *Bulletin*'s readership. Might I suggest that our continuing good relationship with our South African colleagues would be strengthened if we entered into a constructive dialogue about the problem of discriminatory provision of psychiatric services based on race.

SIDNEY LEVINE

Special Committee on the Political Abuse of Psychiatry
17 Belgrave Square
London SW1

Community psychiatry

DEAR SIR

While generally welcoming Dr Greenwood's communication on community psychiatry in the January issue (*Bulletin*, 1982, **6**, 6-8), I feel that there are several points which require comment.

As a psychiatrist with 15 years' experience of varying types of general practice and with some familiarity in the use of the General Health Questionnaire (Corser and Philip—*British Journal of Psychiatry*, 1978, **132**, 172-76), one of the tools used by Professor Goldberg and his colleagues, I must voice my view that his claim that 250 per 1,000 of the general population show frank psychiatric disorder is rather exaggerated. There must be some doubt that what is being measured is a normal range of emotional response to life events rather than actual psychiatric illness.

In her description of the variety and scope of her work, I do not think that Dr Greenwood stresses enough the role of the Primary Care Team, and the fact that all general practitioners in the area where she works do not support the practice of self-referral would give me cause for concern. I feel, too, that, in her summing up of new services needed in the area where she works, she has tended to exceed the role most psychiatrists would now think appropriate, and her own ambivalence is revealed by a statement that the medical and psychiatric training of the psychiatrist is possibly no more appropriate for such work than a social science qualification.

It is disappointing that neither Dr Greenwood nor, apparently, the Working Party on Community Psychiatry has chosen to look at the Livingston experiment (Corser and Ryce—*British Medical Journal*, 1977, *ii*, 936-38) which, despite its imperfections, at least has attempted to look at and improve the relationship between psychiatrists and general practitioners, and to show that psychiatric nurses do not have to confine themselves to caring for the ex-psychotic hospital population.

C. M. CORSER

Bangour Village Hospital
Broxburn, West Lothian

The College's first decade

DEAR SIR

I have been reading with great interest the personal impressions of the College's first decade contributed by the first three Presidents which appeared in December (*Bulletin* (1981), **5**, 218-24), and should like to congratulate them on what they have achieved.

I am only sorry that no mention was made of the important part played by Dr Ian Skottowe in the translation of the old RMPA into the present College during the prolonged negotiations with the Privy Council.

I had the honour of being the President of the old RMPA at the annual meeting held at Basingstoke in 1964 when the decision was taken to approach the Privy Council for the formation of a new Royal College. The majority in favour—if my memory serves me right which it now often does not—was about two to one. At this meeting Ian Skottowe was inaugurated as my successor. So he had to start bearing the burden and did so manfully.

Looking back, a curious amount of feeling was shown at this meeting before the vote was taken. It seemed to be held by some that the formation of a new Royal College would be violently opposed by the Royal College of Physicians. To put the record straight, this is quite incorrect. I happened at the time to be a member of the Council of the RCP, as I had been elected as representative of the RCP in the General Medical Council, and so was well placed to know.

DESMOND CURRAN

51 Cottesmore Court
London W8