letters and other material which reveal the character of these people. I will be very grateful to you if you can study this material and express your opinion on it.

I realize that at a distance and without the essential clinical information it is very difficult to determine the mental condition of a person and either to diagnose an illness or assert the absence of any illness. Therefore I ask you to express your opinion on only this point: do the above-mentioned diagnoses contain enough scientifically-based evidence not only to indicate the mental illnesses described in the diagnoses, but also to indicate the necessity of isolating these people completely from society?

I will be very happy if you can interest your colleagues in this matter and if you consider it possible to place it on the agenda for discussion at the next International Congress of Psychiatrists.

For a healthy person there is no fate more terrible than indefinite internment in a mental hospital. I believe that you will not remain indifferent to this problem and will devote a portion of your time to it—just as physicists find time to combat the use of the achievements of their science in ways harmful to mankind.

Thanking you in advance,

V. Bukovsky.'

Through the efforts of an informal working group on the internment of dissenters in mental hospitals, most of the documents Bukovsky mentions have now been translated into English and are available for psychiatrists who wish to study them from the Hon. Secretary of the group, Mrs. E. C. Aitken, 63 Holbrook Road, Cambridge. This material should also be helpful if, as is hoped, the matter is raised for discussion at the forthcoming International Congress in Mexico.

It could be argued that this is a domestic matter that concerns only the Russians themselves and that people in other countries should not interfere. It is true that the immediate evidence comes mainly from the U.S.S.R., but there have been reports of similar happenings in other countries, and the situation raises wider issues of considerable interest in relation to the rights of the individual when they are in conflict with what are deemed to be the interests of society. Whatever view is taken, the current reports are clearly damaging, not only to good relations between the U.S.S.R. and the West, but also to psychiatry itself in view of the implication that there are psychiatrists who are willing to prostitute themselves in the interests of political expediency.

While the reports should not be accepted uncritically, yet the allegations are there and they cannot be merely brushed aside. The only answer would appear to be a thorough and impartial investigation. In many cases the Russian psychiatrists were not unanimous in agreeing with the decisions that were made and there is reason to believe that many would welcome an investigation of this kind.

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## THE N.A.M.H. 'GUIDELINES'

DEAR SIR,

The need for this Guide arises in the situation where the decision to accept or refuse admission lies with *medical* staff while the problems of violent behaviour have to be dealt with by *nursing* staff. In general the Guidelines suggest that critical *decisions* are the responsibility of nurses rather than doctors. For instance, in paragraph 2 drugs or ECT are spoken of as if it were nurses rather than doctors who decide whether they should be prescribed. My experience would confirm that this is what often happens in practice, however reluctant we as doctors may be to admit it.

I would therefore recommend a reconsideration of paragraph 7, with a view to establishing much more clearly than at present the advisability of bringing nursing officers into the decision-making process as to whether a particular patient should be admitted. It is not sufficient for doctors merely to 'discuss' the question of admission with the nursing services. We should aim for it to become established practice for a nurse to see the patient before admission to a particular institution at a particular time is decided; and in my view it should be the nursing service which should have the power to veto an admission recommended by a doctor. The Guidelines do not face up to the present situation where it is doctors who can overcrowd institutions by too generous an admission policy; while it is nurses who get the blame for subsequent neglect of their duty for patient care.

The implicit problem of authority as exercised by doctors on the one hand and nurses on the other will not be an easy one to resolve.

I suggest that the medical man in a psychiatric hospital has two sources of authority: one is purely clinical—the needs of the individual patient in question. This stems directly from medical training. The other source of authority stems from his position of responsibility in an institution devoted to the care of sick people. This kind of authority assumes that he has management functions which in many respects are those properly exercised by nurses. Thus, as a consultant, I may on the one hand judge that a disturbed patient requires in-patient care; but on

the other hand may consider that because of inadequate nursing staff in the hospital he should not be admitted, as this would mean inadequate nursing not only for this patient but for many others. The latter judgement means that I am performing a *nursing* management function rather than a medical one.

It would do a great deal for the morale of nurses—and thus for their efficiency—if consultants (sic) insisted on acting as *advisers* to nursing staff rather than as *directors* of them. Many nurses would have initial difficulty in accepting this responsibility, of course, but they can only learn if given the opportunity.

Until our profession is prepared to relinquish its defensive fantasies of omnipotence in hospitals, the difficulties which lead to the present discussion of a code of nursing practice are likely to continue.

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DEAR SIR,

I am writing in response to the invitation of the President for views about recent suggestions that there should be either 'Guidelines' or a 'Code of Conduct' for psychiatric nurses, with special reference to the problem of handling violent patients.

Something closely resembling such a code of conduct is to be found in Chapter 5 of the First Edition of the R.M.P.A.'s 'Red Handbook', which was published in 1885 with the title, 'Handbook for the Instruction of Attendants on the Insane.' As successive editions of the 'Handbook' appeared, the method of presentation changed to that of a modern textbook of psychiatry for nurses, and the problem of handling violence was dealt with by showing that good methods arose logically and naturally from a proper knowledge and understanding of mental illness. It seems then that any attempt today to produce either 'Guidelines' or a 'Code of Conduct' for nurses must ignore the direction in which progress has been made, and indeed is simply to put the clock back for nearly a century.

Such action would be doubly unfortunate, as the point requiring most urgent attention has been stressed again and again in the 'Red Handbook'. This is that if a nurse anticipates violence on the part of a patient, he or she should ensure that adequate help is summoned. Overwhelming superiority in numbers usually results in avoiding violence; even if it still occurs, it can in these conditions be overcome with the least possible risk of injury to the patient. If, however, there is a shortage of staff, the nurses are deprived of the most important help they require in handling potentially violent patients, and the real responsibility for this rests with Management.

Indeed, as the Farleigh Report suggests that the tragic events there were the end product of years of mismanagement, perhaps 'Guidelines' or a 'Code of Conduct' should be prepared for the benefit of those responsible for management in the Health Service.

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## ANOREXIA NERVOSA

DEAR SIR,

According to Wright *et al.* (1969) one of the most consistent symptoms of anorexia nervosa is the presence of lanugo. Lanugo is characteristic of intra-uterine life from the fourth month until term, reaching a peak in the seventh and eighth months and falling off thereafter. Most hair growth is controlled by steroids; the steroids present in abnormally high concentration in the foetal placental circulation are dehydroepiandrosterone (DHA) and its sulphate (DHAS), also 16oH-DHAS, oestriol and progesterone. The last two of these continue to rise until parturition, but the others probably decline towards the end of pregnancy because the foetal zone, which produces DHA, decreases relatively to the rest of the adrenal as pregnancy advances. Also DHA is found in the urine of premature babies but not in that of full-term ones (Birchall *et al.* 1961). Since lanugo declines in the same way towards the end of pregancy it seems possible that it is caused by DHA. (DHAS and 16oH-DHAS are less likely to be responsible because conjugated steroids have relatively little biological activity.) Since DHA is thought to be produced only by the adrenals this would seem to implicate the adrenals in the causation of anorexia nervosa.

Against this are the facts that it is practically confined to teenage girls, and is associated with amenorrhoea and also with low oestogen levels, all of which suggest an ovarian disorder. Typically it starts a year or two after menarche (Crisp, 1965). For the first few years after menarche the menstrual cycles are anovular, i.e. there is no luteal phase; so it looks as if anorexia nervosa is associated with the onset of ovular cycles, which would incriminate the corpora lutea. This supposition is strengthened by the fact that the low oestrogen levels (Russell, 1965) are almost wholly due to low levels of oestriol,