

difficult to pass such a clinically based examination without recent experience in a training post.

SHEILA A. MANN, *Chief Examiner*  
FIONA CALDICOTT, *Dean*

### *A register of Munchausen cases*

DEAR SIRS

Lovestone employs several arguments against the use of a national register for psychiatric Munchausen cases (*Psychiatric Bulletin*, September 1991, 15, 581). The most cogent of these is that such a register might constitute a breach of confidentiality. In order to protect confidentiality the register would need to be accessible only to medical staff.

It was suggested that the use of a register is unnecessary for the diagnosis of Munchausen's syndrome. In the case I described (*Psychiatric Bulletin*, March 1991, 15, 167) the diagnosis was considerably facilitated by referring to a Social Services list of "hospital hoppers". More recently I have encountered a case of an aggressive and suicidal man, apparently aged 14, who described a variety of psychiatric symptoms and who gave a history of having received depixol injections. He refused to give his home address. After admission to an adult psychiatric ward followed by a local authority children's home, he is now in a Social Services Secure Unit. It is still unclear whether he has given his true name and age and whether his psychiatric symptoms are genuine.

The assertion that making a diagnosis of Munchausen's syndrome is not helpful since there is no known treatment is surprising. Surely the recognition and documentation of a poorly understood syndrome is a pre-requisite for research into treatment and outcome. Any such research would be facilitated by a national register of cases.

Although Lovestone dismisses the economic benefits of a register these are nonetheless important both in hospitals and in local authority children's homes where there is considerable pressure on bed space. Hospital admission is not only costly but potentially harmful. Repeated admission is likely to reinforce the hospital "addiction" and may be associated with the administration of psychotropic medication which is not without its harmful effects.

My interest in a register is not the result of a fear of being "conned". I do not suffer from an overwhelming urge to consult a register when dealing with patients presenting with somatisation disorders, dissociative disorders or deliberate self-harm. It is the role of the psychiatrist to look beyond the presenting signs and symptoms to the underlying distress and personal dilemma of the patient.

R. I. DAVEY

*Clatterbridge Hospital*  
*Bebington, Wirral*  
*Merseyside L63 4JY*

### *Use of the Mental Health Act 1983*

DEAR SIRS

I read with some disquiet the letter from Dr Azounye (*Psychiatric Bulletin*, July 1991, 15, 455) concerning use of the Mental Health Act 1983. I am extremely uncomfortable with the idea that legislation which has been framed to protect the civil liberties of psychiatric patients should be modified to "make life considerably easier" for psychiatrists and social workers.

Section 3 of the Act contains a very important safeguard for the patients, providing for consultation with the nearest relative. This allows the patient and his family more say in the process of compulsory admission. By admitting someone on a Section 2 this is negated. It is perfectly possible to discharge a patient from Section 3 in less than 28 days, should the patient's clinical condition dictate this.

Section 2 is framed to allow detention under less rigorous conditions in a situation in which the patient is less well known by the clinical team. Where the clinical team has extensive knowledge of the patient and, conversely, the patient and his family have knowledge of the benefits accruing from previous psychiatric treatment, then it seems essential that increased safeguards continue to apply. This view would appear to be endorsed by the Code of Practice (1990), paragraph 5.4 which states that decisions should not be influenced by the duration of proposed treatment.

In addition, where a patient is well known to services, should not the treatment plan be formulated while the patient is in the community and offered without recourse to hospital admission?

JON KENNEDY

*Reaside Clinic*  
*Bristol Road South*  
*Rubery, Rednal*  
*Birmingham B45 9BE*

Reference

DEPARTMENT OF HEALTH AND WELSH OFFICE (1990) *Code of Practice, Mental Health Act 1983*. London: HMSO.

### *Impact of the White Paper on Specialist Services: the Cassel Hospital Survey of Referrers*

DEAR SIRS

Dolan & Norton's findings on clinicians' views about the changes in usage of specialist services such as the Henderson Hospital (*Psychiatric Bulletin*, July 1991, 15, 402-404) are confirmed in part by the results of the Cassel Hospital Survey of Referrers. The Cassel Hospital has a slightly different remit to