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Correspondence

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THE SCOPE OF PSYCHIATRY

DEAR SIR,

During a recent meeting of the North Western division of the College there was considerable discussion of the possible dangers of colleagues in associated disciplines, such as psychology, acting independently of psychiatrists in the treatment of patients within the Health Service. Disquiet may well be appropriate, but should perhaps be mitigated by consideration of the sort of problem that these non-medical professionals seek to treat. It is too easy to consider that an erosion of the boundaries of the proper medical sphere of responsibility is taking place, when in fact it could be equally argued that those boundaries have already become inflated beyond the limits of medical competence.

Demands are being made on the psychiatrist for help with problems for which his training equips him ill, and for which he can find little time in an overcrowded time-table. One movement towards mitigation of this position is expressed in a call for more and better trained psychiatrists, but the evidence is that, even were this wholly desirable, the call is unlikely to be answered in the foreseeable future. Moreover recent criticisms of the workings of our mental hospitals suggest that some retrenchment in the core areas of our responsibility should take precedence over demarcation disputes more peripherally.

This said, perhaps you would allow me to advance a rather more abstract speculation regarding the roots of some of our current dilemmas in respect of our responsibility to those people who differ from the accepted social norms in a way which causes them trouble and unhappiness. These people may define themselves as 'patients' by the simple expedient of consulting their doctors. I am thinking here of those with addictions, sexual abnormalities, poor control of aggression, and parasuicidal tendencies, etc, the vast majority of whom manifest no major psychiatric syndrome.

In relation to these people I would hold that medicine, and psychiatry in particular, has been a social tool (not necessarily in a pejorative sense) in bringing about a major change of public attitude. Many actions considered to merit punishment, and states of mind considered morally reprehensible or despicable, have, by inclusion within the framework of respectable medical practice, become transformed into conditions meriting sympathy and treatment. In historical perspective I think it yet remains to be seen whether this change has brought wholly desirable results or increased the sum of happiness of the age in which we live.

More parochially, it seems to me that we have reached a position which holds considerable dangers for our profession. Having, by our tacit acceptance of so much common human disability and unhappiness as illness, facilitated a change in social attitude, we need to take care that we do not unthinkingly follow through the medical model in which we were trained and too easily accept it as our responsibility to provide 'treatment' for a very significant proportion of the population.

Two serious risks to the psychiatric profession seem to lie in the areas I have mentioned. Firstly, our credibility with our medical colleagues and the public at large may be put into such danger that our advocacy on behalf of the seriously mentally sick and handicapped will lose force. Secondly, our own self-esteem and job satisfaction must be at hazard when we spread our efforts so thinly that we can perceive only a relatively small part of our work as well done.

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LIMBIC LEUCOTOMY

DEAR SIR,

We welcome the useful paper by Mitchell-Heggs *et al* (*Journal*, March 1976, **128**, pp 226–40) on limbic leucotomy, but we would like to question some of the conclusions. It is stated (p 237) that 'In the present series, however, where lower medial quadrant lesions were combined with cingulate lesions, the results are superior', i.e. superior to the results after lesions in the lower

medial quadrants alone. Now, limbic leucotomy and Knight's stereotactic tractotomy (1, 2) both involve a virtually identical lesion in the ventromedical quadrant of the frontal lobe. The difference between the two operations is that with limbic leucotomy there is an additional pair of cingulate lesions, and it is this addition that is claimed to produce increased effectiveness. Studies investigating limbic leucotomy and those assessing the results of stereotactic tractotomy both use grading of outcome from I to V. But scrutiny of the detailed figures shows that apparent differences in effectiveness between the two operations result from, in the case of the limbic leucotomy studies, taking together improvement in three grades, namely I, II and III, while the reports dealing with stereotactic tractotomy consider improvement only in terms of grades I and II. While there are some differences in the definitions, both are dealing essentially with a five-point scale of which three points are identical (I, IV and V). The paper by Dr Mitchell-Heggs emphasizes *definite* improvement with grade III. But the scale as a whole is in fact concerned more with degree than definiteness, although the latter tends to depend upon the former for reliability. In one of the studies concerned with tractotomy (2), it was found that clinical parameters, including treatment needs and numbers of suicidal attempts before and after operation, indicated that group III clinically resembled group IV more than group II. This was also clearly supported by the results of psychological tests. In Dr Mitchell-Heggs' paper, while the mean psychological test results fall significantly after operation, this is shown for the whole group without considering the results in relation to outcome, which would prove more informative. A similar opportunity was unfortunately missed with the physiological data.

In order to attempt a comparison that is as meaningful as possible, the figures given in the two papers on tractotomy can be compared with those in Dr Mitchell-Heggs' present paper but including only those categories about which there is likely to be little dispute, namely I (symptom free), IV (unchanged) and V (worse). These figures can be extracted from the published tables and they make it clear that the additional cingulate lesions are not associated with a clearly better outcome. Copies of the figures we have obtained in this way are available. We therefore conclude that cingulate lesions are not routinely necessary in addition to those in the lower medial quadrants. In particular, with regard to obsessional neurosis, we have found that these cases did as well as a matched group of patients with depression, after tractotomy.

We also feel it undesirable to give the impression of looking back to the unhappy days of prefrontal leucotomy by describing the results for schizophrenia as 'most rewarding' (p 238). The improvement rate of 86 per cent refers to 6 out of 7 patients and 4 of these were in grade III anyway.

Finally, we disagree with the suggestion that operations should only be carried out on patients admitted informally. Of course, the patient's free and informed consent is essential and treatment given compulsorily must never include psychosurgery. But we have had more than one case admitted in a state of severe distress with overwhelming bouts of suicidal impulses. These patients were in complete agreement to having the operation, but they needed the closest nursing supervision in the pre-operative period to avoid suicidal behaviour. Adequate clinical control of such patients seems impossible without the application of orders under the Mental Health Act, 1959.

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