incapacity will continue to attract a legitimacy which far outweighs their validity. The power of psychiatry will continue as before.

We also disagree with Zigmond's (1998) idea that a Medical Incapacity Act would reduce stigma at a stroke, by offering the same protection to all patients unable to consent to medical interventions. Stigma is primarily a cultural, not a legal, issue. Media representations of mental disorder and distress are currently the greatest problem. Journalists have managed to connect the issues of dangerousness and mental illness in the imagination of both public and politicians and, as a result, tolerance towards people with mental health problems is at an all time low. This can only be combatted by a joint campaign of users and professionals. In turn, this will only happen if professionals begin to question the politics of mental health and the limitations of their knowledge in an open way. If psychiatrists continue to assert a simple equation between bodily and mental illness they will miss an historic opportunity to open up a new agenda in the area of mental health.

FULFORD, K. M. (1998) Invited commentaries on: Mental health legislation is now a harmful anachronism. *Psychiatric Bulletin*, **22**, 666–668.

ZIGMOND, A. S. (1998) Medical Incapacity Act. *Psychiatric Bulletin*, **22**, 657–658.

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Mental incapacity

Sir: Szmukler & Holloway (*Psychiatric Bulletin*, December 1998; **22**, 662–665) are misguided to suggest that incapacitated patients would be afforded better protection by the adoption of an Incapacity Act along the lines proposed by the Government Green Paper *Who Decides* (Lord Chancellor's Department, 1997).

The Green Paper gives no guidance as to how, or by whom, incapacity is to be judged and takes no account of 'shades' of capacity or temporary incapacity. Once patients are designated as 'incapacitated', a previously drafted 'living will' may come into force which requires 'treatment', possibly including food and fluids, to be withdrawn, leading to death by dehydration or starvation. Gardner *et al* (1985) showed that patients change their minds when illness strikes them; however, it would be hard for patients to change or withdraw advance directives if they had already been classified as incapacitated. Moreover, suicide notes may under this legislation constitute advance statements. Cries for help could become death warrants. The Bill also makes legal non-consensual medical procedures (Clause 10) and research (Clause 11) on 'incapacitated' patients, even if of no benefit to them. This could include organ removal from a non-dying patient.

Doctors attempting to resist any of the possibilities discussed could be liable to criminal prosecution. Rather than providing the extra protection to mentally incapacitated people which Szmukler & Holloway so laudably seek, this Bill would make possible widespread abuse of these patients and lead to a fatal compromise in medical ethics. Our profession should therefore resist it at all costs.

GARDNER, B. P., THEOCLEOUS, F., WATT, J. W. H., *et al* (1985) Ventilation or dignified death for patients with high tetraplegia. *British Medical Journal*, **291**, 1620–1622.

LORD CHANCELLOR'S DEPARTMENT (1997) *Who Decides? Making Decisions on Behalf of Mentally Incapacitated Adults*. London: HMSO.

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Participation in continuing professional development

Sir: Contrary to Weaver's assertion (*Psychiatric Bulletin*, December 1998, **22**, 771), my editorial (*Psychiatric Bulletin*, September 1998, **22**, 529–530) did not speculate in any way on the continuing professional development (CPD) activities of psychiatrists who have not registered with our College-based scheme. I regret that Weaver seems to have missed the crucial point of my article, which set out to emphasise how important it is that our CPD scheme should be given all possible support. Participation in CPD is only part of what is expected of us. We also need to demonstrate clearly that we have done so. Our scheme is surely the best way to coordinate this process and ultimately demonstrate its effectiveness.

As I predicted, things have now moved apace and some form of revalidation is a near certainty. I can only guess at what this will entail, but I do believe that a well supported College-based scheme should offer psychiatrists several distinct benefits. It is conceivable that College-based CPD credentials might be taken into account in the revalidation process, and they should help to maintain a standard of excellence which is set nationally. A recent survey of attitudes to our scheme has shown that among a sample of consultants who have not registered for CPD, the most common reason for not doing so is an excessive clinical work load. Here too a College based scheme should be well placed to challenge relevant employing NHS trusts in a