Statement. When a prisoner, having completed his sentence, re-offends, public outcry and apportioning of blame often tend to be relatively muted, in comparison with the furore which may follow re-offending by a Special Hospital patient. The rationale employed by society appears to be that once an individual has served the punishment imposed for his crime, then it is correct that he should return to society and if he re-offends agains, the fault lies with him alone. When we hear of recividism rates for prisoners in the order of 80%, this rationale is indeed fortunate for the prison authorities.

The expectation made upon the Special Hospitals is considerably more complex than, as with prisons, merely acting as a vehicle for punishment and containment. Offences must be understood in terms of mental disorders present, and patients maintained in adequate security until such time as these disorders are ameliorated. Not surprisingly such terms of reference result, not infrequently, in longer periods of detention for offenders than would have been occasioned by a prison sentence.

It would appear to me that the Department of Health, as Managers of the Special Hospitals, have a duty to clearly state the purposes and functions of these institutions and bring the recividism statistics of Special Hospital patients into the open, instead of continuing to function, as perceived by the media, behind a 'veil of secrecy'.

Such action might result in more enlightened discussion over the complex problems that the Special Hospitals pose, and perhaps even tempt reporters into making more balanced documentaries than that portrayed in the recent Cook Report. It might also avoid the distasteful scapegoating of Special Hospital Medical Directors, as happened in this particular documentary.

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Psychiatry and the private sector

DEAR SIRS

I fear that Dr Turner is looking only at the negative side of psychiatry in the private sector (*Psychiatric Bulletin*, May 1989, **13**, 249). There is a good deal that the NHS could learn from the independent sector especially in the climate of the Government White Paper, *Working for Patients*. For example it is possible to treat NHS and private patients in the same surroundings. Between March 1987 and October 1988, 66 of Camberwell's most severely ill patients were admitted to The Priory Hospital. Most of them were on Sections of the Mental Health Act (2,3,4 and 136).

The diagnostic categories were as follows:

ICD-9	*Diagnosis*	*Camberwell Health Authority (NHS)*	*Priory Hospital (Private)*
295	Schizophrenia	60%	16%
296	Affective psychoses	29%	28%
300	Neurotic disorders	5%	16%
303 304	Alcohol and Drug dependence	6%	29%
	Other	0%	11%

As expected, there was a higher proportion of schizophrenic patients in the Camberwell sample and more neurosis, alcohol and substance abuse among the private patients. The scarcity of resources for the in-patient treatment of alcohol problems in the NHS has been the subject of a recent televison programme. The percentage of affective disorders was, however, remarkably similar.

The mean durations of stay of both groups were almost identical: Camberwell patients 24 days; private patients 23 days. The Camberwell patients were treated in the same intensive care setting as the private patients. There are no locked doors and there is not a seclusion room. Only one of the Camberwell patients absconded. There were no suicides. It was apparent that those needing a locked facility for forensic reasons were not appropriate. The one patient who did abscond, did so in his pyjamas. When asked where he was going by a fellow passenger on the bus, he replied "To a pyjama party of course". Another patient, who was on a section of the Mental Health Act, was asked by a Mental Health Act Commissioner "Do you mind being in this hospital?" To which he replied "What? You must think I'm mad!"

The NHS no longer has a monopoly of administrative or innovative ideas. It has been demonstrated that the private sector can also be an appropriate place for registrars and nurses from the NHS to be trained. (*Psychiatric Bulletin*, April 1989, **13**, 199). If the White Paper does nothing else, I hope it will reduce the barriers between the NHS and the independent sector. The Royal College of Psychiatrists appears to recognise this, since there is a representative from the private sector on the College committee discussing the Government White Paper.

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Treatment for patients unable to consent

DEAR SIRS

I wonder how many of my colleagues are aware of the implications of the recent decision of the five Law

Lords to allow sterilisation of a severely handicapped 36 year old woman to prevent an unwanted pregnancy. This judgement applies to all types of treatment and is based on the common law principle necessity, which allows doctors to treat unconscious patients in casualty. According to the BMJ's legal correspondent (BMJ, 298, 10 June 1989), this extension of common law can now allow for treatment to patients unable to consent, through mental illness or handicap, if the treatment or operation is in their best interests. Such intervention must be "either to save their lives or to ensure improvement or prevent deterioration in their physical or mental health" (Lord Brandon). It seems, therefore, that such treatment need not be only in the nature of emergency treatment.

This ruling has certain implications for psychiatry. Firstly, in the liaison psychiatry, when we are asked by our surgical or medical colleagues whether they can treat patients with mental illness or handicap who are declining treatment, we should advise them that they can do so. For example, the elderly schizophrenic patient with a gangrenous foot can be treated electively rather than waiting until he is unconscious, and the paracetamol self-poisoner can be given intravenous N-acetylcysteine against his will, as long as some doctor has decided that the person is mentally ill. It is unclear in the Law Lords' judgement whether such a decision that someone is mentally ill has to be made by a psychiatrist.

Secondly, this judgement widens the rift between psychiatry and all other branches of medicine in that under the terms of the Mental Health Act 1983, a mentally ill person who needs but refuses treatment for his mental illness cannot be so treated, except in an emergency, until a second opinion has been sought. The position with regard to psychosurgery is still further divorced from the rest of medicine.

Thirdly, from a general ethical viewpoint, it is interesting to note that this judgement represents a substantial victory of paternalism over individual autonomy as the basis of doctors' dealings with their patients.

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Consultant vacancies

DEAR SIRS

I was interested in the letter from Dr Jolley about unfilled consultant posts (*Psychiatric Bulletin*, 13, 248–249). You might be interested in the other side of the coin, so to speak.

After 20 years service as a consultant I resigned from the NHS to take up an appointment in Canada. For some months all went well then a combination of circumstances decided me to try and return. This was much easier said than done. I telephoned several locum agencies whose addresses I found in the BMJ. Most said they were concerned only with non-consultant vacancies; a few promised to send on their registration forms but didn't. I then took the course of submitting my CV to four Regional Health Authorities asking them to put my name on their locum consultant registers. These applications were sent by airmail, in two cases by Special Delivery. Only one authority actually replied.

In view of my experiences I find the letter of Dr Jolley all the more surprising. The only explanations I can offer are either the number of consultant vacancies has diminished considerably in 1989 or the Regional Health Authorities do not wish these filled.

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Job description – description of jobs

DEAR SIRS

There has been much discussion about job descriptions. Is it time to look again at description of jobs? In the *British Medical Journal* of 20 May 1989, the following posts are advertised under psychiatry:

Consultant Psychiatrist
Consultant Mental Handicap
Consultant in Acute Mental Illness
Consultant in Psychological Medicine (Mental Handicap)
Consultant Psychiatrist (General Psychiatry)
Consultant in General Psychiatry
Consultant in Psychiatry (General)
Consultant in Psychogeriatrics
Consultant Psychiatrists (Psychogeriatrics)
Consultant Adolescent Psychiatrist
Consultant Psychiatrist in Adult Mental Illness
Consultant in Child and Adolescent Psychiatry
Consultant in General Adult Psychiatry
Consultant in the Psychiatry of Mental Handicap

Finally, one Authority is looking for "Locum Doctors in Psychiatry".

Would it not be a helpful convention that, at consultant level, all posts were described as "Consultant Psychiatrist in ...", the appropriate sub-speciality, as defined by the College Sections?

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