Correspondence

South African psychiatry

DEAR SIRS

I refer to the policy statement from the Society of Psychiatrists of South Africa (MASA), (*Bulletin*, May 1985, **9**, 102).

Over the years the Medical Association of South Africa (of which SPSA is a section) have shown a greater interest in shoring up their international credibility than in responding to social and ethical challenges in the field of health care in South Africa. SPSA's policy statement is in keeping with this and their sudden concern about racial discrimination in the field of mental health can only be seen as a cynical attempt to appease Western psychiatric opinion. While it is gratifying to note that international campaigns on psychiatric abuses under apartheid are beginning to have an effect on SPSA, it will take more than self-congratulatory statements to convince us that medical institutions and psychiatrists in South Africa are not subservient to racist governmental policies in the field of health.

Would the SPSA be prepared to spell out the implications of its policy statement and tell us what they are actually proposing to do about the extensive abuses of psychiatry as documented in detail by many observers? Could they assure us that they are committed to challenging the minority government's policy of institutional racial discrimination (apartheid) since without dismantling it there could be no equitable health care system in South Africa? If, for example, the SPSA is prepared to 'strive for the elimination of all forms of discrimination that adversely affect mental health' and to declare 'its opposition to any disparities in the quality for psychiatric services for all', how can these be achieved without challenging the political system that specifically and directly determines health status and health care opportunities along racial lines? While SPSA was trying to win friends abroad its members were busy trying to implement new government policies, based on the new constitution, which racially fragmented the country's psychiatric services into four different groups. How does the SPSA respond to this and the recent resignations of Professor Jan Robertze of MEDUNSA and Dr Jurgen Harms of the University of the Free State who were not prepared to 'perpetuate apartheid principles in psychiatry'? SPSA must also be aware of, if not colluding with, the Department of Health's decision to continue with 'secret private companies' to provide substandard care for black patients—as alleged by Professor Robertze—an issue which first drew allegations of unethical practices against South African psychiatry.[1]

SPSA also talks about 'its determination to resist any form of abuse of psychiatric knowledge and skills for political ends'. What does this mean when some members of the Society continue their active collaboration with the security police in the detention and 'treatment' of political detainees in psychiatric hospitals? When is SPSA going to condemn and attempt to challenge the extensive police torture which causes considerable, and often long-standing, psychological morbidity among detainees and prisoners? Why has it not initiated any inquiry into the circumstances which led to the detention of more than a dozen black activists in psychiatric facilities under security police custody in the recent past? SPSA claims that it had been 'responsible for many improvements in the services', but what is obvious to the rest of the world is that such changes have benefitted mainly the minority of white patients while the black majority continue to be neglected.[2] What little improvement that has occurred in the care of black patients has come about as a result of sustained international pressure in the last 15 years. It is, therefore, altogether not surprising that SPSA have chosen to make a public statement on apartheid and its effects on psychiatry for the first time now as they are clearly worried about mounting international pressure on this issue, like the Helsinki declaration to seek South Africa's expulsion from the World Psychiatric Association[3] and the recent statement from the American Psychiatric Association[4] condemning psychiatric effects of apartheid.

Finally, a word about the enthusiastic welcome accorded to this statement by the President and Council of the Royal College of Psychiatrists. It looks as if the College will accept any excuse to side-step the issue of South African psychiatry. After the Political Abuses Sub-Committee's failure to deal with the substantial issues in relation to the evidence presented to it,[5] the Council appear to be prepared to clutch at any 'good news' from South Africa to justify its endorsement of psychiatric practices in the Republic. In years to come, this episode will be remembered as another sad example of the College's rather selective commitment to dealing with political abuses of psychiatry.

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[2]WORLD HEALTH ORGANIZATION (1983) *Apartheid and Health*. Geneva; WHO.

[3]MEDICAL NEWS (1984) Declaration on apartheid. *British Medical Journal*, **289**, 116.

[4]AMERICAN PSYCHIATRIC ASSOCIATION (1985) *Memorandum: Resolution against Apartheid*, January 1985. Washington, DC: APA.

[5]SASHIDHARAN, S. P. (1983) The College and South Africa. *Bulletin of the Royal College of Psychiatrists*, **7**, 208–209.

The President, Dr T. H. Bewley, writes:

Council discussed the Position Statement of the Society of Psychiatrists of South Africa in March and I was asked to write to their President 'to convey Council's agreement with the views expressed in the Statement.' That Statement 'deplored potentially harmful psychological effects on the people of South Africa as a result of any form of discrimination based on race, colour, gender or creed.' Dr Sashidharan now accuses myself and the College of 'accepting any excuse to side-step

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the issue of South African Psychiatry'. This is unjustified and gratuitously offensive. The College has condemned misuse of psychiatry in the Soviet Union (Quarterly Meeting, November 1978), torture in Northern Ireland (*Bulletin* June 1977, p. 11), and the effects of apartheid in South Africa (*Bulletin* June 1983, **7**, 115). The College pointed out 'that there is substantial evidence that discrimination in the provision of psychiatric services based on race exists in South Africa both in State and Private Hospitals and that this discrimination in the provisions of psychiatric facilities on the grounds of race is to us totally unjust and unacceptable.'

If the Statement by the Society of Psychiatrists proves to be solely 'a cynical attempt to appease Western opinion' (and I hope it is not), then it will be for Dr Sashidharan to show that this is the case. The College's Special Committee on Abuse of Psychiatry can deal only with factual evidence, not opinions. Council has never been involved in 'the endorsement of psychiatric practices in the Republic', as Dr Sashidharan states. It welcomed a statement which positively condemned the ill effects of apartheid. Dr Sashidharan is entitled to promote his views and opinions vigorously. These will carry more weight if he is factually accurate and does not misrepresent the views of Council.

Mental Health Act 1983 (Consent to Treatment): A personal view

DEAR SIRS

The Mental Health Act 1983 ostensibly addresses the issue of consent to treatment, but does little to eradicate the difficulties associated with the treatment of those (severely handicapped) incapable of giving such consent.

Allow me to cite two current cases, which I believe highlight some of the deficiencies associated with Section 58 of the Act. The first concerns a severely handicapped adult (of informal status) in whom dental treatment was advised at a recent case conference. Both the Mental Health Commission and the legal adviser to the Health Authority were unable to furnish definitive advice on whether or not to proceed, although the former were able to confirm my belief that such treatment was in any event outside the scope of the Act.

The second case concerns all those (severely handicapped) residents within the hospital who are receiving long-term oral medication. A recent visit by the Mental Health Act Commission suggested that such residents should be 'sectioned' in order that this treatment may be legally given. This advice in turn raises more questions than answers, most notably: (a) Is it justifiable, or legally correct, to invoke the Act, where it is clear that treatment is proceeding on an informal basis, and without any overt protest or objection (thus negating at least one prerequisite of Section 3)? (b) If the Act were invoked, would this enhance the rights of the individual by ensuring a second opinion (provided for under Section 58) from the Mental Health Commission, or simply result in an otherwise informal patient being unnecessarily 'sectioned'?

It is clear that treating informal patients (incapable of giving informed consent, albeit with the consent of their next of kin) under common law, where a definitive legal position is lacking for either party, is unsatisfactory to both patient and care givers alike.

Although provision is allowed for within the Act for such forms of treatment as may be specified by regulations made by the Secretary of State, the Act as it now stands is insufficiently comprehensive in specific terms to deal with the former issue of dental treatment, or inappropriate in the latter case (of drug treatment exceeding three months).

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Trainees and research

DEAR SIRS

In 1980 Dr Helena Waters, then Chairman of the Collegiate Trainees' Committee, surveyed trainees in the Southern Division, at the request of the Executive Committee, to determine the extent of trainee involvement in research. The results of the survey have never been published, but we feel they might usefully be reported in the *Bulletin* as it would interest us to know whether other Divisions have any comparable figures, obtained before or since 1980, which may help to suggest how the situation is developing.

The survey

Four hundred questionnaires were sent to trainees in the Southern Division. Trainees were asked for information about their grade, the hospital in which they were working, their interest in and current involvement in research, and the availability of facilities and supervision for research.

There was a 25 per cent response rate. Replies were received from 16 SHOs, 51 registrars and 28 senior registrars. For the purposes of analysis the trainees were divided into junior trainees (SHOs and registrars) and senior trainees (senior registrars).

The majority of junior trainees (76 per cent) and senior trainees (86 per cent) who completed the questionnaire were based in teaching hospitals. The vast majority (93 per cent) also expressed an interest in undertaking research. At the time of completing the questionnaire, 32 of the 67 junior trainees (48 per cent) and 22 of the 28 senior trainees (79 per cent) were currently engaged in a project.

Junior trainees based in non-teaching hospitals were almost as active in research (44 per cent) as those in teaching hospitals, but this was not so at senior registrar grade where all reporting involvement in research were based at a teaching hospital. Roughly a quarter of both groups were registered for an MPhil or a PhD, and all these were at teaching hospitals.

Fewer junior trainees (39 per cent) than senior trainees (68 per cent) reported that adequate supervision was available, and a small number of trainees (22 per cent of juniors and 4 per cent of seniors) had been unable to arrange supervision when trying to begin a project. Thirty-three per cent of junior trainees and 64 per cent of senior trainees felt that there were adequate research facilities (i.e. access to statistical advice, computers, etc) available to them locally.

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