the advantages of a larger regional centre, with fostering of interest and maintaining some expertise locally. All patients to be notified to the regional centre. Other recommendations are made concerning staff for the regional centres and it is suggested that this can be achieved by redeployment. It is also suggested that an adult physician, probably one with an interest in respiratory disease, should be identified to work with the cystic fibrosis paediatrician and joint adolescent clinics set up. Finally, the regional centres should pool data for research.

Overall, this is a very sensible compromise, but one wonders how it will work in practice. It always needs an enthusiast to deal with long term handicap and they are not always neatly arranged as hoped in these recommendations.

The report is perhaps particularly interesting for the Child and Adolescent Psychiatry Specialist Section as it illustrates a general problem of who will care for the adult long term handicapped and how will this be done.

March 1986

Correspondence

British psychiatrists in Canada

DEAR SIRS

Further to G. M. Green's article about British psychiatrists in Canada, (*Bulletin*, April 1985, **9**, 77–78) I would like to add to the comments of other correspondents on this subject.

In the Province of Ontario psychiatrists in mental hospitals have been in dispute with the Government for almost a year over working conditions and staffing levels among other things.

Because of this dispute we recommend that anyone applying for an appointment in the Ontario Psychiatric Hospital system should get information on the present status of this dispute. Contact Dr John C. Deadman, Ontario Psychiatric Hospitals & Hospital Schools Medical Staff Association, c/o Hamilton Psychiatric Hospital, Box 585, Hamilton, Ontario, Canada L8N 3K7.

JOHN C. DEADMAN

The Mental Health Act

DEAR SIRS

Dr L. D. Culliford (*Bulletin*, February 1986, **10**, 38) has pointed out one area of dispute where the Mental Health Act is less than clear and entrusts eventual clinical responsibility and interpretation to the attending physician's judgement. Recently we encountered another situation when the Act proved unclear.

A severely depressed middle-aged lady on a Section 2, who was refusing food and drink, was felt to require a course of ECT. As she was unable to consent, the relevant office of the MHA Commission was contacted and a second opinion (Section 58) was obtained. A course of 12 ECT was recommended. This would normally involve a time span of six weeks giving ECT biweekly.

Though the patient's condition improved somewhat, the Section 2 expired before an adequate course of ECT could be administered. The patient became informal and did not consent to further ECT which were felt necessary.

Under the circumstances, should a Section 3 be invoked and the ECT continued though there may not be enough grounds clinically to justify this decision? Or should ECT, as recommended by the approved doctor from the MHA Commission under Section 58, be continued even though the patient was now informal and clearly did not consent to ECT but was still in need of it?

The MHA 1983[1] recommends that 'A course of treatment or plan of treatment may be continued if the patient has withdrawn consent, if the RMO considers that the discontinuation of the treatment or plan of treatment would cause serious suffering to the patient. In all such cases treatment must cease as soon as its cessation will no longer cause serious suffering'.

The implications of some of the terms are debatable. In this case the patient, though clinically less depressed, was well enough to commit suicide. Does the authority of the treatment (12 ECTs) recommended under Section 58 extend till the course is completed or does this authority get invalidated once the other Section (in this case Section 2) expires?

P. CHOWDHURY

Middlesex/St Luke's Hospital
London

R. S. SIWACH

Bethlem Royal Hospital
Beckenham, Kent

REFERENCE

[1]MENTAL HEALTH ACT (1983). *Memorandum on Parts I to VI, VIII and X*. London: Department of Health and Social Security.

Alcoholism and the Mental Health Act

DEAR SIRS

In an earlier issue of the *Bulletin* (February 1986, **10**, 38), Mr G. K. Roberts, an official of the Medical Defence Union, while responding to Dr Culliford's query on the above subject, appears to be suggesting that although alcoholism *per se* does not justify detention under the provisions of the Mental Health Act 1983, delirium tremens may justify detention under the provisions of

the Mental Health Act if the Responsible Medical Officer considers this as amounting to mental disorder.

I would like to suggest that the best way of dealing with delirium tremens is to admit the person in the first instance to a medical facility under common law, rather than to a psychiatric setup under compulsory order.

IQBAL SINGH

Leavesden Hospital
Abbots Langley
Watford, Hertfordshire

Medical détente with the USSR

DEAR SIRS

In relation to your correspondent's appeal on behalf of Dr Anatoly Koryagin, who was recently elected to Fellowship of the College (*Bulletin*, December 1985, **9**, 244), I should like to make two comments.

Your anonymous correspondent wants the Koryagin family's immediate emigration to be made 'an absolute condition of any cooperation with the health organisation of the USSR'. We, however, believe that cooperation with the Soviets in matters of health and medical exchange will also promote understanding in other aspects of humanitarian concern, including justice and peace. We consider that a medical *détente* will be of benefit to all concerned.

Your correspondent continues, 'these 'doctors'... couldn't even care less about the health of the 'free' citizen of this country, so is it likely they'll care about prisoners?' Any abuse of medicine is to be deplored, but such should not lead us to damn the whole Soviet medical profession. Although there is considerable disparity in the quality of health care throughout the USSR, and the Soviet doctors themselves admit this, a great effort is being made to achieve a uniformly high standard of health care. There remains much to be done, as indeed there does here in Britain, but, considering the constraints under which the Soviet doctors have been working, and not least that of the destruction and death toll of World War II, their achievements are considerable.

J. R. ROBINSON

UK–USSR Medical Exchange Programme
480 Banbury Road, Oxford

DEAR SIRS

The use in Dr Robinson's letter of such expressions as 'medical exchange' and 'medical détente' needs clarification.

These expressions have meaning only in the context of professional relations with the Soviet Union if there exists an equivalence in the professional status of doctors in the Soviet Union and the democracies. However, the concept of an independent profession simply does not exist in the Soviet Union. Doctors, and in particular psychiatrists, who are permitted to attend international congresses or meet foreign colleagues are specially selected representatives whose loyalty is not in doubt and who are frequently trained to present official views in terms acceptable to the West. Any discussion on the political misuse of psychiatry is invariably met with a bland denial in the face of firm and convincing evidence. The ordinary Soviet doctor is 'protected' from Western contacts and Soviet doctors know better than to approach Western doctors directly through any but the most secret channels.

Two instances illustrate this sad state of affairs. Some time ago, Dr Kazanets wrote a scholarly article on the application of the concept of schizophrenia in the USSR which was published in *The Archives of General Psychiatry*. Following this article, the College invited Dr Kazanets to lecture on this topic at a College meeting. Dr Kazanets enthusiastically accepted the invitation but did not attend because he was refused a visa by the Soviet authorities. Subsequently he lost the job he had at the Serbsky Institute.

The second incident involved the Scientific Attaché at the Soviet Embassy in London. He sought a meeting with a representative from the Royal College. Dr Sidney Levine and I met him at his Embassy on one occasion and at the College on another. At the first visit he enquired about the College's views on the political abuse of psychiatry in the Soviet Union. He refused to entertain even the possibility that such practices occurred in his country. At our second meeting, the problem of closer co-operation between Soviet and British psychiatrists was raised. He was very keen for the College to have a small conference here with Soviet psychiatrists, but insisted that these representatives would have to be arranged by the Soviet Embassy and not through our personal invitations.

PETER SAINSBURY
Chairman—Special Committee on the Political Abuse of Psychiatry

Note Dr Anatoly Koryagin's new address is:
SSSR 618801,
Permskaya abl.,
Chusovskey r–n,
St. Polovinka,
Uchr. VS 389/37,
USSR.

Mother and baby units

DEAR SIRS

I would like to make a few comments on the paper by Shawcross and McRae (*Bulletin*, March 1986, **10**, 50–51). The writers feel that for a catchment population of 190,000 a specialised unit would not be appropriate and were hoping to explore with neighbouring districts the possibility of providing a joint mother and baby unit. Whilst I agree that a specialised unit is perhaps appropriate for a large catchment area population e.g. 500,000, I do not agree with the rest of the conclusions, particularly that a satisfactory facility could not be provided in a general adult psychiatric ward.

I work in the East Surrey Health District with a catchment population of 186,600 and we have had a mother and