E.C.T. CURE OR CURSE

(with apologies to Hilaire Belloc)

Electric treatment is the cure
For everyone both rich and poor.
It cheers you up, it calms you down,
It takes away your worried frown,
It fattens you if you're too thin,
It even helps to cleanse your skin.
It moves your bowels, clears your head
And stops you wishing you were dead.
What scientific sceptic could
Question anything so good?
But there are some who say it's bad
To ill-treat those who're feeling sad,
By giving artificial fits
Which then deprive them of their wits.
It's all (they say) one of the tricks
Of those who practise politics,
Reducing non-conformity
By use of electricity
(Which is a very dangerous force
As everybody knows, of course,
And never should be put, they think
Into the hands of some old shrink).
For something subject to abuse
Can never be of any use.
If you should happen to suggest
Submitting data to the test
And setting up a double-blind
To see if anyone can find
Whether it works, and why and when
And if it's safe, you'll find that then
They'll shout you down, they'll be as one
For one thing they're agreed upon
Is that the facts would interfere
With the opinions they hold dear.

O let us never, never doubt
What nobody is sure about.

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CORRESPONDENCE

AN OPEN LETTER TO THE PRESIDENT*

DEAR SIR,

I am writing to express concern about certain trends in the policy of the College. I am referring to manpower requirements for teaching and non-teaching districts, and the part teaching hospitals should play in the provision of psychiatric services. I believe a Working Party is now considering these issues, but I feel that a wider debate within the College might be appropriate. I know from discussions with colleagues in different parts of the country that my misgivings are widely shared, but the views expressed here are my own, and not those of any organized group.

I can think of four basic models for a University department of psychiatry:

(1) A Professorial Unit of, say 10–15 beds, with an 'academic' role, i.e. primarily teaching and research, and staffed by the University. If the main teaching hospital has a sizeable psychiatric unit, the rest of the beds would be—in terms of staff and clinical work—part of the district services.

(2) A University department of substantial size (whether in general or psychiatric hospital) operating on a selective basis, i.e. without district service responsibility, and seeing their role as 'academic', with service functions secondary to the academic ethos and interests of the department. The major part of the staff would hold academic appointments, with a small (below what is considered 'normal' for units undertaking a full district service) contribution from the NHS.

(3) A University department which is part of the district service for clinical purposes with a 'normal' or average NHS medical complement. Additionally, it also has University appointed staff. To the extent that psychiatrists in University posts take on clinical commitments, they relieve NHS staff, allowing them time for academic pursuits.

* President, then Professor W. Linsord Rees, agreed to the publication of this letter in the *Bulletin*.

(4) A University department which is an integral part of the regional, or where there is more than one Medical School, of the sub-regional psychiatric service. Senior and junior staff is shared—through joint appointments or rotation or both. Teaching at all levels, undergraduate as well as postgraduate, is shared out regionally.

It is essential to make a choice between the available models, with the clichés 'élitist' and 'egalitarian' describing succinctly the opposing ideological poles. My purpose is not to advocate a particular model but to draw attention to the staffing implications of the different models. The University should not be expected to fund NHS functions; the reverse of this statement is equally true. Few will dispute the enormous importance of the Maudsley for the development and scientific standards of British psychiatry. But is it possible, or even desirable, to aim—in England and Wales alone—for 25 undergraduate University departments of psychiatry modelled on the Maudsley? The question is not whether the University hospital should, or should not, provide a district service but whether the University department should opt out, instead of being an integral part of it?

The role of the University departments needs to be clearly defined in every case and their claim to the NHS, as opposed to University, medical staff determined by the model they choose. We have high hopes for the academic departments, many of them young and inadequately funded, but they have not improved recruitment into psychiatry and it is unlikely they will do so in the future. It could be argued that a narrowly academic training will deter doctors whose interest is clinical; a wide gap in staffing levels between teaching and regional hospitals makes for reluctance, in those who trained in a well-staffed University department, to join the hewers of wood and drawers of water of regional hospitals. There are signs that this is already more of a problem in psychiatry than in other major clinical disciplines. A teaching increment from NHS resources—even if it were justified—would tilt further the balance in favour of teaching hospitals and reduce the number and quality of psychiatrists available outside it. At a time when there were no academic departments, a relatively large medical staff could be justified since they had to carry out academic as well as clinical functions. Where there is an academic department the justification for an above-average NHS staffing disappears. I am referring not only to Consultants but to medical staff of all grades, from Senior Registrar to Senior House Officer and Clinical Assistant.

When deciding differential staffing needs, we should not be content with the self-congratulatory term of 'centres of excellence'. What exactly are the areas for which any one centre claims excellence? For the whole spectrum of psychiatric practice? For some islands of it? By what standards have they been found excellent? Psychiatrists who would, quite rightly, insist on stringent criteria before accepting minor scientific or therapeutic advances should not make global and emotive claims to obtain preferential treatment. The size of the staff in any one part of the service, and the proper source for funding it, should be determined by objective criteria—type of work, its quantity, grade of seniority required for it—and not by *a priori* considerations.

The claim for a teaching increment—additional to full-time University staff—is based on the requirements of teaching, research and administration in the University hospitals. The undergraduate teaching could—and perhaps should—be shared with regional hospitals, with the academic department functioning as co-ordinator, rather than the sole dispenser, of teaching. This is of course happening in certain centres. Most of postgraduate training takes place in regional rather than in teaching hospitals, and the College formally approves their standards. While University centres have an important role to play in postgraduate training, it would be hard to justify an NHS teaching increment over and above their University staff, when none is accorded to those hospitals which train the majority of junior doctors. Regarding research, more of it is desirable in University as well as in regional hospitals. However, there are not many University or regional hospitals that can boast of their record in research. It should be possible for consultants, wherever they work, to exchange NHS sessions against part-time posts with the MRC or the University, or to have a joint appointment from the outset. As for administration, a senior regional consultant may have as much, and often has more, administrative work as his opposite number in the University hospital; his clinical duties are usually heavier, and he carries them with a supporting staff which is often lesser in number and in quality.

The role of the College goes beyond the functions of setting educational and professional standards. It represents our views to the DHSS, the Home Office and other authorities on a wide range of issues, some of them predominantly if not exclusively of a service character. In this respect it functions both as a Royal College and as its humbler predecessor, the RMPA. To do this effectively, the Council and the main policy-making committees should reflect fairly closely the sectional interests of psychiatric practice. I am not referring to representation by sub-specialty; this

is only adequate when dealing with the educational functions of the College. But what proportion of members of the Council and its key committees has no academic appointment or University affiliation? If only a minute percentage, is there not a danger that the needs of, and problems experienced by, the majority of psychiatrists may be overlooked? It is not a question of good will: this is not in question. By the nature of things, each section sees its own situation in sharper focus than that of its neighbour. It is also likely that regional consultants may be better informed about, and have more direct experience of, some of the problems the College has to consider. Elections are of course open and democratic, but over-worked regional consultants, unable to delegate their responsibilities, are not keen to stand and take on additional medico-political work. The College should address itself to this problem and find a solution to it. Less disparity between staffing ratios may lead to a more representative College structure. The RMPA was considered by some to be a 'Superintendents' club'. We must avoid the emergence of an updated version of this cynical description.

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CORPORAL PUNISHMENT IN SCHOOLS

DEAR SIR,

Our memorandum on corporal punishment in schools (*Bulletin*, April, pp 62–4) illustrates once again the hazards of straying out of one's field of expertise. Our learned representatives rightly note that any comments must be based on 'informed professional opinion' as there are few special studies on the subject, but then venture the conclusion that 'there is nothing to support the continuance of corporal punishment in schools'! As there is no evidence for or against, why should we recommend abolition?

Some conspicuous absurdities in the memorandum perhaps result from a failure to consult psychiatrists who have taught in schools (there are a few such). For example, 'many children are themselves horrified by the idea that teachers should inflict physical punishment on a child' is unbelievably naive, unless we are speaking solely of neurotic children and special schools. It is more difficult to excuse the failure of logical thought behind the repeated comment that 'the same names appear over and over again in the punishment book'. By this argument the Maudsley, too, should be abolished, since the same names appear over and over again in our admissions book.

I deeply regret that our representatives have tendered a memorandum without considering the practical realities involved. These include:

(i) a society which continues to force its children to attend school by law, regardless of interests or desires, up to an ever-increasing age limit;

(ii) an educational process which includes compulsory mathematics, history and religion, subjects which have little appeal to a substantial and vociferous minority of children;

(iii) social mores requiring teachers to suppress various natural activities of children while in school, including homosexual and heterosexual drives;

(iv) a political system demanding that teachers cope simultaneously with groups of 35–40 children, often of varying abilities and interests.

In these circumstances, as in an army, there must regrettably be means of coercion. The College has misread its brief in attempting to recommend whether punishment itself is desirable: the problem is *which* punishment?

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Dr Carr's letter was forwarded to Dr J. H. Kahn, who was the Chairman of the Committee which produced the Memorandum on Corporal Punishment, and the following is his reply:

DEAR SIR,

Dr Carr points unerringly to the confusion which arises when two opposing principles are followed simultaneously to their logical conclusion. In this case the principles are the freedom to choose one's behaviour whatever the consequences, as against the enforcement of what is thought to be good together with prohibition of what is thought to be bad. A balance is achieved by the acceptance of changes in what is tolerable within a particular community at a particular time.

The use of corporal punishment in schools is no longer as generally acceptable as it was in the past. Views amongst the general public and amongst psychiatrists are not uniform, and those initially responsible for the College Report on Corporal Punishment in Schools did not expect the unanimous agreement of their colleagues.

Dr Carr's criticisms can themselves be challenged. I take it that his suggestion that the Maudsley 'should be abolished' was not meant seriously, but if treatment