for importance of experiences, although, not surprisingly, percentages expressing satisfaction were overall 10-20 points lower. The largest discrepancies between importance attached and judged adequacy were in two areas: firstly in the field of disorders associated with physical illness and developmental disorders; secondly in the area of learning disorders and behaviour therapy. It is interesting that these are two areas in which other professionals are most likely to be involved. The former two groups are often referred to paediatricians, and the latter have increasingly been regarded as falling within the expertise of psychologists. Nevertheless, because of the association of these disorders with psychiatric problems, the psychiatrist's contribution is important, and the acquisition of experience during training is necessary. It is an open question whether the present perceived inadequacy is due to low emphasis in training programmes, or whether it is connected to faulty interdisciplinary adjustment.

The study reported here was limited to a sample of trainees, and in order to improve on its validity a more comprehensive survey is now in progress. From the present study, it can be concluded that respondents are on the whole in agreement with current training guidelines, but for the benefit of training in child psychiatry areas have been identified which deserve further investigation.

ACKNOWLEDGEMENTS

Thanks are due to senior registrars for their patience and co-operation in completing the questionnaire.

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The Limits on Freedom

DEAR SIR,

Compulsory treatment is an emotional issue for the Press and members of the public, hazy about the law's safeguards and the real situations psychiatrists may face. Two recent cases make me think some of our members may be equally confused about the valid limits of permissiveness. A little open discussion of these limits may be useful, to see what others think.

A young student at the start of his career had three admissions in quick succession to different hospitals because of attacks of a psychotic illness with bizarre withdrawal, sudden violence, paranoid delusions and hallucinations. The second and third admissions were compulsory under Section 25. On the third he proved very difficult to control but eventually settled with regular injections of an intramuscular depot phenothiazine. He was discharged, attended out-patients regularly, and was able to resume his education while living at home. He had completed three terms, when his parents moved with him to another part of the country. Unfortunately his treatment faltered, and his symptoms began to return. He became paranoid, frightened his parents with aggressive outbursts, and wrote a letter threatening death to a former neighbour who had become involved in his delusions. He was seen by a local psychiatrist, who had information also from the patient's previous admissions, but decided he could do nothing because the patient himself said he did not want any further treatment. This left the problem with the parents, whose family life was already being ruined, and the father in fear of physical injury. It also jeopardized the student's future since he was unlikely to be able to continue his studies properly while so liable to paranoid disturbance.

The second case was that of a research scientist of 40, who for the previous five years had been unable to work; his marriage had disintegrated, and he was drifting in and out of hospital as an informal patient. Whenever he came in he was so suspicious and uncommunicative that he would not agree to let the doctor contact his previous medical attendant, or any previous employer or teacher. In consequence, information needed for establishing a certain diagnosis had not been sought, and prognosis depended on the evidence of a static or slowly deteriorating state over five years. However, he had sometimes been persuaded to take phenothiazines, and had thus improved and discharged himself or been discharged; but he would not continue treatment once he was out, and often failed his out-patient appointments, and his condition deteriorated again.

The outlook for the future functioning of both these patients appears black: yet there is evidence in both that

proper treatment with a neuroleptic drug would suppress the psychosis and enable them to lead near-normal self-supporting lives. Why have their doctors not treated them, therefore? The questions for discussion are:

(1) Does the patient always know best? Are there not certain illnesses which by their very nature distort the judgement so that such a sufferer's opinion of the need for or value of treatment may be quite mistaken from every view, including his own self-interest? Are there not occasions when the psychiatrist must take the responsibility of treating the patient who refuses treatment, if he is to do his best for that patient? If so, what are the occasions?

(2) Is it wrong (and if so, why?) to seek information confidentially from (a) another doctor (b) anyone else who has known the patient previously, if the information is to be used only for the diagnosis and treatment of the patient, will be kept confidential, and will not be sought in such a way as to alert the patient's enemies or potential employers to his state of illness? Is it necessary always to seek the patient's permission, and abide by a refusal of it?

(3) A patient on a Section 26 is at the doctor's orders for 12 months, but of course he does not have to stay in hospital all that time; he can be sent home and back to his work, while the Section's effect continues. That is, he can be recalled quickly to hospital at any time if the responsible medical officer wills it, and if he will not return voluntarily he can be collected by nurses or social workers, or even by the police. Of course, these provisions must be used responsibly, in the interests of the patient's treatment or the safety of others. Is it wrong to exercise this power, and if so, why?

I know a few people claim that there is no such thing as mental illness, or that what we call the individual's illness is his labelling as a deviant by Society, and his response to that, but such ideas are contradicted by experience of the full range of psychoses, for instance in mental hospital work. The anxiety that purely deviant individuals or social rebels may find themselves compelled to conform is better founded, which means that the boundaries of what constitutes psychosis must be sharply defined. Isn't this one of the reasons we have psychiatrists? Aren't those psychiatrists who refuse ever to use compulsion professionally irresponsible?

CHARLES SNODGRASS

London, W2.

DEAR SIR,

The Mental Health Act's original purpose was to formalize the compulsion of patients, allowing our conduct to be observed and if necessary criticized, and providing ways to appeal against it. I have watched with interest its gradual transformation in the minds of both staff and public into a set of regulations limiting our duty. This mutation is now complete (*Bulletin*, Dec, p 189)—patients needing admission were allowed to leave a Casualty department because Section 29 could not be completed.

Have we forgotten our rights as doctors in Common Law to treat a patient according to his needs? A little more courage is needed, perhaps, as one has to do without the protection of S.141, but competent action in good faith is still our right.

On three occasions recently I have compulsorily admitted patients to hospital without completing section 29, as our local social workers were on strike. After careful discussion the administration supported this action as appropriate, and indeed necessary. I wonder what would happen if any of those patients allowed to leave the Casualty department sue us for negligence?

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(See Correspondence in *British Journal of Psychiatry* (1979) **135**, 482; and (1980) **136**, 200-2.)

Research in Decline

DEAR SIR,

I was stirred by Dr Crammer's rousing call for more research in mental hospitals (*Bulletin*, November, 1979). In the interest of a broad debate, may I express a view which differs in some respects from his own?

He identifies ignorance, haste and lack of forethought as the main reasons for bad research in mental hospitals. I should like to suggest that these are not fundamental causes, but only symptoms of more deep-seated difficulties. If so, his own prescription—an advisory service—however valuable, might not be enough.

I believe that the real obstacle to research in mental hospitals is that most have a tradition, organization and outlook conducive to clinical work and not to research. This is neither surprising nor a matter for complaint, but it does impose three important limitations on research—lack of time, lack of specialization and, here I very much agree with Dr Crammer, isolation. These, I believe, are the real reasons for the amateurishness which he detects in papers submitted from mental hospitals.

Lack of time is the major constraint. As well as caring for patients, the psychiatrist working in a mental hospital, being a clinician, will be sympathetic to exhortations to provide marital therapy, group therapy, crisis intervention, pastoral care, etc.; in fact his timetable begins to look like the overburdened conspectus of other people's enthusiasms. But above all, psychiatry cannot be hurried.