Brit. J. Psychiat. (1973), 123, 609–15

Correspondence

PSYCHIATRY AND DISEASE

DEAR SIR,

Dr. Hershon's comments on Professor Roth's paper, 'Psychiatry and its critics' (*Journal*, 1973, *123*, 130–31) themselves deserve comment.

Dr. Hershon states that it is 'generally acknowledged that one of the fundamental aspects of the medical model is the patient's inability to control the disease directly by willpower so that he cannot be held responsible for it'. 'Generally acknowledged' by whom? Certainly not by dictionaries, a review of which reveals no reference to willpower in definitions of disease.

Dr. Hershon says that people whose 'behaviour . . . brought about the acquisition' of a disease do not have a disease. Alcoholics are an example. Cancer patients have 'absolutely' no control over their illness, alcoholics have 'some'. Ergo, cancer is a disease, alcoholism is not. Nor, by this definition, are some cases of lung cancer, where the smoker knows the risk and *could* stop but doesn't.

In fact, how a disease is acquired may have no bearing on its disease-ness. Acquiring it may even be fun. What is Dr. Hershon's view of syphilis?

Finally, Dr. Herson says diseases must have a demonstrated physical aetiology. It is difficult, though, to name many diseases whose aetiology is fully known. Bugs cause infections, but not everyone with bugs has an infection, so there must be something more . . . etc. From acne to zuckergussleber, the story in medicine and psychiatry is mostly the same: cause unknown.

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HOW ESSENTIAL ARE PSYCHIATRIC SERVICES?

DEAR SIR,

Those outside the psychiatric services sometimes look upon Departments of Psychiatry as a luxury, and the life-threatening nature of many psychiatric illnesses goes unrecognized. The recent hospital strike provided us with a natural opportunity to discover how many patients could manage to do without the hospital service without endangering their lives. The Department of Psychiatry of the University Hospital of South Manchester comprises 160 general psychiatric beds and a 9-bedded mother-and-baby unit, and provides a total psychiatric service for approximately a quarter of a million people. There are no arrangements for transferring patients needing long-term care to mental hospitals, and since we opened in January 1971, we have been gradually accumulating chronic, undischargeable patients.

During the strike, all drivers of hospital vehicles withdrew their services, and this meant that the laundry and deliveries of essential supplies stopped. Food continued to be delivered to the hospital, so that meals could be provided for the patients. We continued to be responsible for the medical needs of the population during the strike, and no patients, to our knowledge, went to other hospitals instead. The medical staff of the hospital took two measures to deal with the strike which are relevant to the present communication. First, each consultant reviewed all the patients under his care, and patients were discharged if they could be sent home without appreciable risk to life and if they had a home to go to. Second, during the strike the patients could only be admitted to the hospital if there was an appreciable risk to life or if to have refused admission would have permanently impaired health. It occurred to us that it would be a matter of great interest to see how far a department of psychiatry would be affected by such measures, and we kept careful records during the strike. The meeting at which all patients resident were considered for possible discharge was held on 1 March 1973, and the strike ended on 30 April.

Numbers of patients resident

Of the 127 patients resident on 1 March, 15 (12 per cent) were discharged in addition to the routine discharges. The mean daily bed occupancy had been 127 for two months prior to the strike (S.D. = 5·3 beds), and it became 114 during the strike (S.D. = 3·6 beds). Within three days of its being known that the strike was going to end—and nearly a week before the official end of the state of emergency—our numbers on the books had returned to 127 and they continued to rise thereafter. It therefore proved possible to reduce the average bed occupancy during