The musical idiot savant

DEAR SIRS

The rare examples of *idiot savants* with musical ability deserve special mention (*Psychiatric Bulletin*, August 1990, **14**, 475–476). While arithmetical or calendar calculators are remarkable enough, they at least require only one main skill, viz. the ability to memorise and/or calculate using a limited number of mathematical rules. On the other hand, the ability to play, note for note, a tune heard only once or a few times, has several components, each of which is unusual even among people of normal intelligence. The first component is an exceptional auditory memory (perhaps 'eidetic'?) to register and recall the melody and harmony; the second is perfect pitch, whereby the tune can be reproduced not just with the notes in correct relationship to each other, but in the original key; and the third is the motor skills and dexterity necessary to play the tune. The latter skill may be highly developed, as in the case where a piano is played manually while a guitar is strummed simultaneously with the toes.

Even if the *idiot savant* has no musical creativity to accompany these abilities, they remain an extraordinary group of skills. Their investigation, both psychologically and using neurophysiological and neuroimaging methods as suggested by Schipperheijn & Dunne, may provide valuable insights into the mechanisms underlying musical abilities in the general population.

PAUL HARRISON

Department of Anatomy
St Mary's Hospital Medical School
London W2 1PG

Childhood autism as a disturbance of neuronal migration

DEAR SIRS

The brief review of Schipperheijn & Dunne (*Psychiatric Bulletin*, August 1990, **14**, 475–476) of the interesting phenomenon of the *idiot savant*, offers a number of hypotheses in explanation, among them, intense practice and appropriate reinforcement. A further hypothesis arises from the elegant elucidations of the phenomenon of neuronal migration (Hatten, 1990). If the various manifestations of childhood autism were speculated to be the result of a disruption of these processes of cerebral development, then it is entirely possible that certain layers or regions of the cortex might be more richly endowed than normal with neurones, arrested in their migration. This greater population might then allow a relative "hypertrophy" of the cerebral function subserved by that region.

Quantitative neurocytology (Harper, Kril & Daly, 1987) might be a means of testing this hypothesis which offers the possibility of examining the cerebral basis for certain cognitive processes.

G. NEIL CONACHER

Psychiatric Services
Treatment Centre
Box 22, Kingston, Ontario
K7L 4V7

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Patients' ability to give consent

DEAR SIRS

I was pleased to read that someone else had realised the importance to psychiatry of recent legal decisions (Jelley, 1990). However, the author fails to develop certain themes which are important to consider in any forthcoming debate. One such theme is the issue of who decides on a patient's ability to give consent and how. Arguably, this should be the province of the psychiatrist. Since psychiatrists' experience of treatment under the MHA has resulted in the development of expertise in assessing the capacity to give consent, it is vital that this expertise is explicitly conveyed to trainees. This will also mean teaching trainees about medical ethics.

Another important theme is that of the conflict between paternalism and patient autonomy. The new Code of Practice incorporates the Law Lords' decision in the case of F v W Berkshire HA, 1989, which allows for treatment of mentally ill patients unable to consent as long as such treatment is believed to be in the patient's best interest. This fails to give guidance on a definition of 'best interests' and also implicitly upholds the 'doctor knows best' school of thought, which many might quarrel with. Further, a Court of Appeal judgement (Wilson v Pringle, 1986) has allowed a defence to the charge of an unlawful battery to be that in acting as he did, the defendant did something which was generally acceptable in the ordinary conduct of daily life (Hirsch & Harris, 1988). This judgement, like the term 'best interests' is vague and open to abuse. It potentially strengthens the paternalistic camp and must be of concern to those who worry about patients' rights and the risks of our specialty alienating its clients further.

L. M. LOVETT

University of Liverpool
Royal Liverpool Hospital
Liverpool L69 3BX

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Adequate provision of study leave

DEAR SIRS

I commend Dr Lucas and the CTC (*Psychiatric Bulletin,* August 1990, **14,** 501) for drawing the College's attention to the problems of trainees in obtaining study leave. This, however, is not just a matter for the College. Dr Lucas neglects to mention the Regional Study Leave Committees to whom juniors can appeal if their leave applications are rejected by district committees.

The regional committee will assess the application on the basis of regional guidelines and can direct districts to grant leave that has previously been refused. Appeals will usually be considered retrospectively.

As a junior representative on the SE Thames Regional Study Leave Committee it is my impression that the appeals procedure is underused not just by trainee psychiatrists but by all specialities and should be more widely publicised. That committee does not regard exceeding an arbitrary financial limit adequate grounds for refusing study leave that is otherwise appropriate. This is an important mechanism by which juniors can counteract the disturbing trend to cash limit, to which Dr Lucas refers.

I would echo Dr Lucas' call for the College to stress that adequate provision of study leave should be an essential prerequisite if a post is to be approved for training. This will be even more important in the reformed NHS where there will be increasing pressure on study leave budgets and where the role of the Regional Study Leave Committee is uncertain.

I was concerned to read, for example, in the *Guy's Lewisham and Mental Illness Services Application for NHS Trust Status,* in the section titled Junior Staffing Issues (p. 5(6)):

> "We will uphold the Whitley Council terms and conditions of service for pay, leave allowance and other main conditions, though we may need to agree ceilings for certain entitlements, such as funds for study leave. . . ."

This ominous statement suggests that in this Trust study leave for juniors is not a "main condition" and may be an area for economy. If leave allowances are to be capped in the new NHS it is essential that the College ensures that they are capped at a level which allows adequate training opportunities for all trainee psychiatrists.

PAUL MCLAREN

Guy's Hospital
London SE1 9RT

Promoting the personal

DEAR SIRS

I welcome the trend in August's *Journal* and *Bulletin* towards articles and reviews that centre on the 'person' of the patient – using the word in a more ordinary way than the 'Californian' or even 'psychotherapeutic' sense!

Two doctors described their own experience of being psychiatric patients – Campbell's *Not Always on the Level,* reviewed by Hugh Freeman, *Journal,* August 1990, **14,** 316–317; and Anon's 'View from the bottom', *Psychiatric Bulletin,* August 1990, **14,** 452–454. (Why do we have to have personal experience of our own medicine before we discover such an essential aspect of our work, even though we always insist such awareness is part of our "normal clinical practice" (Thompson, see below)? It couldn't be that there is a basic fault in modern medical and psychiatric training, could it?)

Two articles showed how the person's viewpoint can inform our work better – *Working with the Person with Schizophrenia: The Treatment Alliance,* by Selzer, Sullivan, Carsky and Terkelsen, New York: New York University Press, 1989, reviewed by Chris Thompson, *Journal,* August 1990, **157,** 309–310; and 'Writing to the patient', *Psychiatric Bulletin,* **14,** 467–469.

This is rich and instructive literature. Since we believe it is about "our normal practice", there should be lots more waiting to be published. Yet such articles are rare in your pages. Audit should eventually help highlight this aspect of our work. And the modern moves to market everything may force us to think of what the "customer wants – though our "customers" are the least likely to find their voice. But are there further ways that you and the College can specifically encourage more work and authors like these? Please.

NICK CHILD

Child and Family Clinics
49 Airbles Road
Motherwell ML1 2TJ

Catch-22 and community treatment orders

DEAR SIRS

In his case report (*Psychiatric Bulletin,* July 1990, **14,** 402) Dr Gareth Jones describes the adverse effects of the recent ambulance dispute upon an elderly schizophrenic. He states that: