inappropriate, particularly as this was the patient's third episode of drug induced SIADH. The temporal relationship between the institution of zopiclone and the onset of hyponatraemia seem to support a causal link.

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Mental health review tribunals' role in assessment of dangerousness: a cause for concern

Sir: A recent experience made me aware of a serious defect in the tribunal system. I saw a woman on a domiciliary visit. She had already that day attacked two other people. At first she was mute, then got up and came back with a plank of wood and assaulted me with it.

After admission, under Section 2, she calmly said that she had intended to fracture my skull and rationalised that I would have acted similarly to a stranger coming into the house not wearing an identification label. She also exhibited grandiose delusions. Depot antipsychotic medication was necessary. She also showed low thyroid functioning and thyroxine was started. She appealed and appeared before the mental health tribunal. Her mental state was unchanged and she again gave her rationalised reasons for her aggression. She showed no insight.

The tribunal made her informal, on their doctor's grounds that she had hypothyroidism that could be treated at home. Also as hypothyroidism was seen as the cause of the psychosis, antipsychotic medication was not felt to be required. The dangerousness was ignored. The other panel members had accepted the doctor's evaluation.

I submitted an official complaint. It was forwarded to the regional chairman of the mental health review tribunal. We then, informally, discussed the situation. The feedback was:

(a) Tribunals cease to exist or function once the case has been heard. In other words, there is no machinery to feedback concerns about the decision.

(b) There was no money available from Government sources to train, and monitor the standard and quality of the work of the members of the tribunal.

(c) I was advised that our local mental health trust could take the decision before a judiciary but that would be a lengthy and expensive procedure.

The case highlights a potentially serious loophole in our ability to keep patients in hospital, when in clearly dangerous states of mind.

There is a need for a regular review of the level of competence of board members, and the need to provide refresher courses, where examples like the one given, could be used for teaching purposes.

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The hare and the tortoise

I must have heard this story when I was a child, how the hare was distracted from his goal by various adventures and great fun, while the tortoise, in a determined, boring, persistent way, reached the end of the race. I never thought then that I would identify with this story and live through it.

Like the hare, I spent my years in the medical school, I passed every year with honours, hopeful about the future, and looking forward to the future as a practising physician.

The final year in the medical school was dramatic. A strange attack of diplopia which lasted for a couple of months and resolved spontaneously, the MBBCh with honours several months later, and soon afterwards generalised weakness in the right lower limb which persisted despite intensive physiotherapy. Several months later, with various investigations and provocative neurological tests, I was diagnosed as suffering from multiple sclerosis: no cause, no treatment and the prospects of physical deterioration and incapacity.

The era of the hare came spontaneously to an end as I had to adopt the challenging qualities of the tortoise: perseverance, patience, determination, to do my best in order to reach my goal. I proceeded as a psychiatric senior house officer in a reasonable degree of physical health, no walking aids and success in obtaining the first part of the MRCPsych. The following couple of years as a registrar proceeded with a relative degree of reasonable physical health, now using a walking stick and I obtained the final part of the MRCPsych qualification. I was very grateful to God that I had reached what I thought was my goal, but was it?

I proceeded through the following years with two elbow crutches and the equivalent of high psychiatric training. Now I am a consultant, still on the elbow crutches, my speed is not very different from that of the tortoise. I am not as

physically able compared with last year, but intellectually and clinically I am proceeding and gaining more by the day.

Yes, the flesh is weak but the spirit is eager.

Why am I writing this letter? Two reasons: the first is a plea to enable me. It was a long arduous road, I am grateful to everyone who helped me, but please enable me. It took me a long time to ask for help, even God wants us to ask, seek and knock, so why shouldn't I? All I am asking for is a parking space at the hospital doorstep, a lift which works, handrails where appropriate – accessibility is what I need and am asking for. The second reason is a call for all those who are physically disabled psychiatrists, please let us join forces together in order to continue, proceed, and satisfactorily reach our goal. Don't give way to the illness and don't allow the NHS to disable us by inappropriate or deficient facilities.

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