

Correspondence

Consultant "scapegoats"

Sir: At the recent Annual General Meeting (AGM) of East Anglian Division there was a unanimous expression of support for our consultant colleague, Dr Dianne Le Fevre and a rejection of the criticism she received in the Woodley Report into the murder of a psychiatric day patient by Stephen Laudat. She was rebuked for making no positive contribution towards the care of Stephen Laudat who suffered from paranoid schizophrenia and had a history of illicit drug misuse. Mr Laudat had only ever been treated with neuroleptics compulsorily when behavioural abnormalities were apparent. He was secretive and opposed the need for treatment. On discharge from hospital he was behaving normally and had been medication-free for 18 months. He made no attempt to see a general practitioner or Dr Le Fevre following his discharge, although this was an agreed part of his aftercare plan. Some ten months later a neighbour noticed odd, noisy behaviour from Stephen Laudat coming from the privacy of his own flat but as the neighbour had an antipathy to Social Services the statutory services were not alerted. This was shortly before the fatal assault.

The Woodley Report, while criticising Dr Le Fevre, contradictorily stated that no specific actions of mental health professionals would have altered the tragic outcome. Dr Le Fevre's responsibility as a consultant includes the delegation of duties while retaining accountability but her contribution in out-patient clinics, multidisciplinary meetings, and Section 117 reviews would not have secured Stephen Laudat's compulsory re-admission to hospital for restarting medication given that he was behaving normally. Blaming Mental Health Services for getting things wrong if patients intend to deceive is most unhelpful. The "scapegoating" of consultants for both lack of resources and poor managed service developments looks like an increasing trend with more than twenty current inquiries still to report. Trusts conspicuously fail to support consultants in public and the division felt that the College ought to give a strong lead to its Membership at a time when morale in the profession is falling from increasingly unrealistic service expectations loaded upon it by central diktat.

Succumbing to a feeling of helplessness is tempting when it is remembered how a consultant in the Clunis Enquiry was chided for having taken on too much responsibility although an unpredictably volatile component of contemporary psychiatric practice is the apparent

irresponsibility of patients who use illicit drugs in the community.

M. R. LOWE

Chairman, East Anglian Division

Learning disability and health care provision

Sir: In *The Children of Leros* (*British Journal of Psychiatry*, July 1995, **167**, Suppl. 28) it was not just shortage of resources which posed problems in improving the lifestyles of people with learning disabilities but the resistance among staff to change and their attitudes towards their stigmatised charges. This theme was echoed in Dr Verma's article (*Psychiatric Bulletin*, July 1995, **19**, 442-444) regarding the need for a more coherent approach to health care provision to learning disabled people in Wales. General Practitioners (GPs) need to be educated about the health care needs of this formerly 'invisible' group invested with 'otherness' by virtue of ignorance.

In the South East of England we have succeeded in closing hospitals and reprovided in a variety of ways, and most districts have community outreach teams giving help and advice to people living locally. One is lulled into a false sense of security about this and I would like to share four insights I have recently gained which question seriously how far we have come.

- (1) A distressed nurse came to see me. She works in our NHS residential service caring for 'dually diagnosed' people - those with mild learning disability and mental health problems. She had asked for appointments for two clients to see their GP for very good health reasons. This particular GP is paid visiting medical officer sessions by us in respect of the increased morbidity of this group of patients. His response was "These people are a drain on my time and a waste of the country's resources".
- (2) A patient on the borderline between dull normal and with learning disabilities suffers from depression due partly to his life circumstances. He decompensated when his marriage broke down. He is treated with antidepressants and has a lot of professional support but no social milieu. When admitted to hospital with suicidal ideation, a general psychiatrist said to his care manager: "These subnormals have no place in mental health beds. Dr Bates should have her own beds".