Correspondence

President's statement

Sir: The President's editorial 'What are Royal Colleges for?' (*Psychiatric Bulletin*, December 1998, **22**, 721–723) is timely.

Consultant psychiatrists are already submitted to scrutiny far more than any other speciality – I have counted 11 forms of scrutiny, but others may be able to add to this. They are Mental Health Act Commission visits, Mental Health Act Review Tribunals, Manager's Hearings, second opinions under the Mental Health Act for treatment, accreditation visits for senior house officers, Joint Committee on Higher Psychiatric Training visits for specialist registrars, postgraduate dean visits, local inquiries, trust serious incident enquiries, Department of Health enquiries and the Health Advisory Service visits. We are enquired into so much that at times there is a feeling of persecution, particularly from the Serious Incident Enquiries that are held every time there is an untoward death. Nonetheless, we must recognise that if all the deaths of surgeons were enquired into as is now the custom in psychiatry then appropriate action could have been taken at an earlier stage in Bristol. I understand that Serious Incident Enquiries into surgical misadventures are very rare even though in principle they are little different from suicides in psychiatric patients. It is unlikely that the monitoring of psychiatrists will be reduced so let us make the best of it.

If the information derived from this vast system could be integrated we would be in a position to claim that we are very advanced indeed in self regulation. I would suggest for each trust there should be a College-appointed person independent of the trust management, but acceptable to them. Nearly all these inquiring bodies would include members of our College and with the permission of the body, the member could communicate with the College appointee observations made on consultant function. Any one source of information could be contaminated by antipathy or lack of sympathy by the observer; but if more than one source indicated concern then this would be grounds for some action. The major role of the College is educational and there would be great difficulties in going down the disciplinary road – in any case we have the General Medical Council for that. Where there are worries about consultant function it will often be the case that the consultant has been given an impossible job with inadequate resources. The College appointee could discuss the issues with the consultant and often the appropriate action would be to alert the trust management to the resource issue. In other cases it may be apparent that the consultant is sick, ill informed or deficient in qualities of leadership. There are existing procedures for sick doctors that are usually invoked at a very late stage of sickness and this would be a means of getting help earlier. For the other problems the College could provide counselling which hopefully would improve the consultant's function, but if not, the counsellor would understand the issues sufficiently to be able to judge whether there was some other procedure that would be helpful with the ultimate possibility of referral to the General Medical Council competence procedure.

I doubt whether it is possible to design a useful revalidation system, largely because a lack of knowledge contributes much less to poor patient management than do the personality and style of the consultant to which my suggested approach would be more sensitive.

Finally it would be helpful if all our colleagues could demonstrate some political realism by enrolling in the College scheme for continuing professional development.

OSCAR HILL, *Consultant Psychiatrist, St Luke's–Woodside Hospital, Woodside Avenue, London N10 3HU*

Sir: I was very interested to read Dr Kendell's editorial on the function of the Royal Colleges (*Psychiatric Bulletin*, December 1998, **22**, 721–723) and would of course agree that the various Colleges have undoubtedly maintained and raised the standard of postgraduate medical training. I would disagree, however, with the idea that the position of the Colleges is being undermined by the incompetence of a very small minority of its members. The vast majority of doctors do not appear to me to be either incompetent or venal and are usually very good, and that includes a number of our psychiatric colleagues who have had the misfortune to be lampooned by the media for supposed misdemeanours and scandals.

The central problem would appear to be that the public, perhaps encouraged by the media, have come to expect an Utopian state of perfection from doctors in which so called errors

are not tolerated. Unfortunately, several of those perceived errors are the result of no more than our natural inability to predict the future accurately all the time, compounded in the case of psychiatrists by the expectation that we will somehow eradicate any violence to the public from anyone who has ever consulted a psychiatrist – and this in spite of any adequate legislation. This is supported by the evidence that over 85% of suspended consultants are reinstated because the complaints against them have been found to be unjust, but these unjustly suspended doctors suffer stress and humiliation and their colleagues become increasingly fearful that the same may happen to them. Genuine errors of judgment will also occasionally occur because doctors are only human like everyone else.

It is therefore my opinion that for the Colleges to believe that their "limitations as self-proclaimed guardians of high clinical standards" have been exposed is to play into this damaging prevailing philosophy. To expect that audits and guidelines, national or otherwise, will eradicate all errors is a very dangerous assumption because it is patently false.

Attempting to practise in a culture where human error is not tolerated and doctors daily fear accusation has taken its toll and has resulted in a drop in recruitment and a rush of early retirements, certainly where psychiatry is concerned. If the Colleges feed into this culture by forging "an alliance either with NHS employers or with the General Medical Council in order to obtain the powers over qualified specialists which they currently lack", this must be done very sensitively or their members are likely to feel even more criticised and unsupported and morale will surely plummet further and this is not ultimately in the public interest.

The Royal College of Psychiatrists has launched what would seem to be an excellent public campaign to reduce stigma against people suffering from mental health problems. This is laudable, but it is a common perception of its members that they too are being increasingly stigmatised and vilified for reasons which are outside of their control. It is important for the College to appreciate this and to consider addressing this issue, perhaps by another public campaign tackling public attitudes, awareness and understanding of what the nation can reasonably expect of its psychiatrists. There need not necessarily be a conflict in furthering the interests of both patients and their doctors, and indeed as members pay their Colleges sizeable subscriptions most will expect that their Colleges will look after their interests in return.

ANNE CREMONA, *Consultant Psychiatrist, 2 Maids of Honour Row, Richmond-upon-Thames, Surrey TW9 1NY*

Psychiatry and the Mental Health Act

Sir: We would like to thank Szmukler & Holloway (*Psychiatric Bulletin*, December 1998, **22**, 662–665) for their comments on the Mental Health Act. Their review article raises important questions. However, while we agree with many of their ideas, we believe that there are substantial problems with their position. They argue that current mental health legislation is both contradictory and discriminatory, as recently highlighted by the L. *v.* Bournewood 1997 Court of Appeal judgement. They propose that Mental Health Act legislation should be replaced by an 'Incapacity Act', which would apply to mental and physical illness, and 'dangerousness' legislation to cover the need for public protection. These proposals contain much that is to be commended. A mental capacity act with statutory rights to advance directives, patient advocacy and judicial appeals against treatment is infinitely better than more coercive legislation.

However, we agree with Fulford's (1998) argument that equating bodily and mental illness is simplistic. This is implied both in the paper by Szmuckler & Holloway and the linked editorial by Zigmond (1998). For example, Szmukler & Holloway declare that: "there is no logical reason to discriminate between mental incapacity occasioned by mental disorder and physical disorder" and Zigmond says: "this (Medical Incapacity Act) would provide for the medical treatment, both mental and physical, of those who lack capacity from whatever cause". Our clinical experience, rooted in our daily contact with people in severe distress, has led us substantially to question the accepted wisdom that distress can be adequately grasped within a medical idiom based on concepts such as pathology, diagnosis, investigation, treatment and prognosis. Human experience resists reduction to causal scientific models. Most of our work, as psychiatrists, is concerned with the interpretation of behaviour in relation to individual personal and social contexts, not the explanation of this behaviour in linear causal terms. We believe that while the medical sciences, upon which psychiatry is based, can inform our interpretations of madness and distress, they can do so in a limited way only. Historically, this explanatory potential of psychiatry has been exaggerated and thus its power to predict behaviour. As a result, society has invested it with the power to detain and to treat patients against their will. We believe that it is time for psychiatry to give up both this power and the associated idea that it can render mental disorder within a scientific paradigm. The two issues are inextricably linked. If we continue to maintain the latter, the implication is that medical perspectives on mental