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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

the strike by 10 per cent. During the same period the general wards of the hospital—medical, surgical, geriatric and obstetric—were able to reduce their bed occupancy from 776 to 625: a drop of about 20 per cent. It is of interest that a smaller proportion of psychiatric beds are used for non-life-threatening conditions than general beds.

Admission rate

In the two months prior to the strike the average weekly admission rate had been 20·1 (S.D. = 4·1). During the strike it proved possible to reduce this by one quarter, for the average weekly admission rate was 15·1 (S.D. = 3·2). In the week immediately after the strike had ended, the admission rate rose to 26 and dropped back to normal over the course of the next month.

Mean duration of stay

The patients who were prevented from being admitted because of the strike would presumably have been short-stay patients, since the mean duration of stay during the strike increased from 40 days to 49 days. It took 7 weeks for the mean duration of stay to return to its previous level.

Comment

It would appear that one quarter of our admissions, but only 10 per cent of our beds, are accounted for by conditions of limited duration which are not life-threatening. The remainder of our beds are occupied either by life-threatening illness or by patients who are unfit to be discharged into the community because of the severity of their disabilities. Much of the value of the figures given depends on the rigour with which individual clinicians applied the criteria concerning risk to life or permanent injury to health. In the author's unit we did not discharge a patient if we thought there was appreciable risk of suicide, although we did discharge some patients several weeks earlier than we would otherwise have done, and some psychotic patients were discharged to be managed at home even though we thought hospital care would have otherwise been in their best interests. Most of the patients admitted during the emergency had either attempted or threatened suicide, and the admitting doctor thought that there was a real risk of suicide if the patient was not admitted.

Despite the reduction in admission rate and bed occupancy the work load for the clinical teams was if anything increased during the strike, with additional pressures on our out-patient department and day hospital. The findings seem to indicate that in a modern psychiatric unit in a general hospital the vast majority of patients need to be where they are.

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DAY HOSPITALS' FUNCTION IN A MENTAL HEALTH SERVICE

DEAR SIR,

I must accept very largely the criticisms of assessment and follow-up procedures in my study of 'A Day Hospital's Function in a Mental Health Service' levelled by Drs. Carney and Sheffield (*Journal*, August 1973, p. 250). At the same time, it may be a little ungrateful of them to chastise a caterpillar for failing to be a butterfly: within its limits the poor creature was doing its best.

Perhaps I can clarify the apparent contradiction about widening the scope of day hospitals on the one hand, and being more selective regarding psychopathic personalities on the other. It appears that to date most day hospitals have limited the types of patients treated, either deliberately setting up a programme (e.g. for the senile, subnormal, or adolescent) or unthinkingly selecting or accepting the sort of patients conventionally felt to be suitable (e.g. the chronic psychotic and neurotic, or the convalescent). But it is my contention that a day hospital which is well-staffed, has access to emergency beds, and has good links with community agencies, should be able to offer a superior service for a wide range of patients requiring active treatment who otherwise might have to be admitted to a mental hospital or psychiatric unit as in-patients.

It is also my belief that a proportion of so-called psychopaths are rewarding to treat if a suitable treatment milieu is engineered for them, e.g. the confrontation and support of peer groups in a therapeutic community. However, at the beginning of the Day Hospital at the Ross Clinic, because of a reluctance to antagonize colleagues referring patients to us, we accepted patients with personality or character disorders who were not only not amenable to treatment but also caused considerable disruption in the unit. For some time now we have tried to be more selective with this category of referral.

Of course, this raises the important question posed again by Drs. Carney and Sheffield: what classes of patient are likely to benefit? It seems to me that traditional diagnostic categories are of small assistance, and my own experience often suggests that conventional guidelines can usefully be ignored. But