driving, or batteries of tests provide the most valid information. O'Hanlon (1988) argued that only real driving performance can measure the effects of drugs, whereas Hindmarch (1988) suggested that the small but significant impairments produced by drugs will not show on overlearned tasks such as driving and that batteries of laboratory tests are necessary. Another difficulty in assessing the clinical importance of drug induced psychomotor impairments is that tests are usually performed on subjects who have taken the drug for only a few days.

Doctors should be familiar with the guidelines contained in *Medical Aspects of Fitness to Drive* but many will be unaware of the particularly stringent guidelines applied to vocational drivers. This will become even more important if, as in Canada, patients, or their victims, begin to sue doctors for failure to advise patients on their fitness to drive (Coopersmith, 1989).

In practice the restrictions will often mean the end of a driving career and could make some people reluctant to seek treatment which might lead to increased risks. There is a special difficulty if a patient will not notify the authority of a disability. Doctors should then follow the advice of the General Medical Council, so that confidential notification may be made to the medical adviser at DVLC without the patient's consent if the doctor feels it is in the public interest.

We wonder if the regulations are excessively restrictive given the limited empirical evidence of increased accident rates in people with psychiatric disorders and believe that informed debate on this issue is required.

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The search for 'the medical model'

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This article attempts to describe a senior manager's search for 'the medical model' in psychiatry in two large provincial teaching units. I was brought to a number of realisations and moved to write this article by watching the film 'Awakenings'*. This portrays with great sympathy and effectiveness the angst and real pain suffered by a neurologist watching his patients in relapse and being powerless to help them. This was reminiscent of many of my consultants describing their own feelings.

*This film was reviewed by Anthony David, *Psychiatric Bulletin*, 1991, **15**, 522–523.

Policymakers – white, male, 40s graduates from the '60s – know what is wrong in psychiatry. They confidently assert the medical model, (which, while never being defined, really meant organic treatment of organic symptoms with an organic cause) the psychiatrists, and institutionalisation. Likewise having done most of my reading and thinking in the 1960s, I was aware that all of the problems of mental illness centred around the existence of 'the medical model' and recalcitrant and backward psychiatrists. Having worked briefly in the field of learning disabilities and had some of these suspicions confirmed, I went to work in mental health. I was only too ready to hear

the nurses' and social workers' opinion that "if only I could deal with the doctors' power, the social workers and the nurses would be able to solve most problems of mentally ill people".

During my first two years as a Unit Administrator in mental health in Nottingham I was unable to uncover, in detailed one-to-one conversations, precisely what a 'medical model' was or who was practising it. The concerns were too evidently to do with poverty and social conditioning and discussions were too frequently about philosophy, social policy, medicine or theology (when they were not about resource management) to enable me to even locate this alleged cause of all problems.

I moved to Newcastle which for decades had had a national reputation as a haven of biological psychiatry. The Professor had made his reputation in research in the biology of the brain. The first unit the Professor asked me to establish certainly included chemotherapy but also operated an intense psychological model. He also continued to refer patients for analytic psychotherapy, cognitive therapy and was an effective but discreet supporter of MIND.

The first ward consultant I met who had a fine reputation as a diagnostician, lectured me about the number of inappropriate patients in in-patient care and asked what I could do about access to housing and creating better housing opportunities to enable early discharge.

Perhaps the psychogeriatricians might help. Clearly their patients' major presenting condition was organic. Regrettably, it turned out that the psychogeriatricians were more socially orientated than the geriatricians and insisted on full multidisciplinary team assessments and doing much of their work in local authority residential homes and believed that talking to home helps was an important part of creating a domiciliary service based around social support.

Where oh where was my 'medical model'? The alcohol and addictions consultants were hopeless for this purpose, regarding medicine as a minor part of their major task, and the young persons' psychiatrists kept taking a broad view of the world, looking at the whole family and issues of maturation and education. The psychotherapists were obviously a non-starter so where could I go?

Perhaps an examination of ECT usage might be helpful. Well it might have been ten years earlier but the medical staff had already carried out reviews on the use of ECT and had criteria for treatment tightly nailed down.

Over the following six years I met with all the consultants on several occasions and discussed with them their approach to diagnosing, prescribing and treating patients. On virtually every occasion I came away having been confronted with a doctor operating under a bio/psycho/social model and not the 'medical model'. I became aware of the intense seriousness of purpose that galvanised this group and the personal experiences which served their clinical practice. The consultant staff emerged as radical and left wing intellectuals who understood better than their critics the profound effects of poverty, poor housing, family and social support.

I spend much of my time resisting the stereotyping and stigmatising of people with mental illness. As a fellow patient at one time I have shared that experience. I have also felt anger, frustration and despair at different points in my treatment and recovery. Many years on I have a perspective on this which acknowledges my perceptions, psychiatrists' successes and failures and the constraints under which we both laboured. It is not good enough to indulge in stereotyping of the medical profession. There may well be lazy and indifferent consultants. If so, they are not working in the Newcastle Mental Health Trust. There may be consultants who make mistakes and every one of our consultants is included in this list. Mistakes include misjudgments in presentation, misjudgments of personal relations and so on. That is different from attempting to apply a world view that is contrived and constricted.

Is it concern for status that social workers and nurses, lacking the science and having only the humanity, seek to downgrade this aspect of medical science to try and achieve greater equality? There is considerable disparagement and it is often so crude that it emerges as an attack on the scientific method itself rather than its weaknesses as a tool in this arena. It is undoubtedly a mixture of motives that includes legitimate concern and jealousy. Perhaps also there is frustration that this tool could be so efficacious in physical medicine and yet relatively impotent in the face of the suffering caused by schizophrenia and affective disorders. On the whole, psychiatry probable benefits from the vigilance that such criticism imposes. I would like to think that, whatever the prime motivation for this behaviour, there is an underlying human concern that combines the caring professions together.

My experience is that consultants do not rush to diagnose mental illness. Indeed, one of the most serious problems a number have shared is how are they going to tell people they are not mentally ill. They hate the lack of knowledge which prevents them from being more effective. But they have watched too many panaceas fail, too many theories crumble to believe in anything other than the steady plodding of the scientific method and the double-blind trial. In the meantime elastoplasts for the wounds are the best the limited first aid cupboard can provide, whatever the wound and whatever shape the plaster.