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Correspondence

Political psychiatric football (Australian Rules)

DEAR SIRS

Psychiatry often becomes involved in political machinations and the character of these varies from country to country. Australia has an extensive and diverse land mass. Australian Rules Football is played on a large oval piece of turf, often called the "XXXX Cricket Ground" and has rules appropriate to this image. The ball is kicked or "handballed" (?bowled) down to the other end and then over the boundary between two conventional tall posts to score a six. To miss kicking a six but to cross the boundary just outside these two posts scores one point and is called a "behind", meaning it is "beyond" the boundary and should have really been a boundary for four. There are posts to indicate this inaccurate part of the boundary but beyond them the usual rules of football more or less apply to the rest of the cricket ground.

It is usual in most countries for psychiatrists to tend to congregate in the large capital cities so they can have direct dialogue with the political aggregate. More than half the Australian contingent population live in the five mainland capital cities. The proportion of psychiatrists in these cities has changed from 82.5% for 57% of the people in 1977 to 90.2% for 55.5% of the people in 1987. Burvill (1988) reports that psychiatrists practising full time in country areas have declined from 11.8% in 1980 to 6.2% in 1987. So the Metro team has plenty of psychiatrists to fill every position from full-back to full-forward and the rovers to international conferences. Ellard (1988), in writing that "the skills of the general psychiatrist are no longer adequate for many of the common disorders of psychiatric practice; instead one needs an assemblage of suitably qualified" is clearly referring to a Metro team.

What of the rural teams? And "rural" to capital city dwellers means everywhere else. What of those on the wrong side of the Great Divide, or beyond the Tropic of Capricorn? The ratios for the numbers of people for each psychiatrist are relatively astronomical as are the distances compared with the intra-metropolitan ones. North Queensland is all in the tropics and has a population greater than the State of Tasmania where there are 34 psychiatrists. Data derived for 1977, 1980 and 1987 show that the Queensland Metro team psychiatrists increased from 51 to 109 to 109 to 155 and living with only 45.4% of the people. At the same time the rural team moved from 20 to 26 to 23 for over half the State population. Obviously the rural team was more than a bit thin on the tropical ground.

The Metro teams were aware of some of the shortage problems; in February 1986 the Federal President wrote that

> "This College should publicly take a position of advocacy for rural practice and appeal for tangible political recognition of the needs for skilled psychiatric input into rural health services. In the absence of this endeavour we will lose the goodwill of our few colleagues who frequently struggle on despite an unacceptable sense of being in psychiatric quarantine, and abdicate our responsibilities to other professions more than willing to do without psychiatric expertise."

This might almost have been read by a local tropical politician, recently promoted to be opposition shadow minister of health in the Queensland Parliament. He began to take an interest in the local Hospital Boards affairs at a time when the rural psychiatric team's resources to meet the requirements of patients and relatives were becoming increasingly strained. The politician, wanting his shadow activities to be more visible, went public in the local paper in March 1986. He became a distant observer of the rural team play.

As if in a press box, well insulated from the real game, he began to comment critically on the rural team's player(s). His team of expert advisers on the game, a bevy of women helpers, script writers, gossip seekers, seductive double agents, and a foreign interpreter, seemed to be more interested in getting on the front page of the press than in obtaining any real assistance for the rural team, and their patients. His quasi-psychiatric team took over the expert role and had a field day blaming everyone and everything they could lay their hands on or conjure up by hook or by crook. He did score a lot of visibility for his shadow in the local, state and national press and on the broadcast media, using members of his quasi-psychiatric team. The gross shortage of real "rural" psychiatrists and other staff was never mentioned.

As a member of the Legislative Assembly he had access to the Metro team management and significant members and a safe place to voice his highly critical comments of the rural team players in *Hansard* for posterity. He would naturally be told by the metropolitan elite of the international standard of excellence established in the metropolitan area by the Metro team. This only gave the politician more grounds to criticise the rural team play when he returned to the tropical area. Maddison (1981)

argued that this use of "excellence" was to be found at the opposite end of a dimension from relevance. What the rural team needed (and they had been saying so out loud since 1980) was some more team members. A few players from a team of international excellence (say Liverpool) could, if they played for a less excellent team (say Hartlepool), be a great help to the team and their supporters.

It is regrettable that this political psychiatric grandstanding team has continued into 1989.

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Coroner – A change in practice?

DEAR SIRS

I gave evidence at the inquest of GD yesterday. I expected my role to be fairly straightforward as it seemed to me a clearer case of suicide than usual. Admittedly, I had not seen him for two years but then he, after admission, had been so self destructive in the ward (an unusual happening these days), that he had a special nurse assigned for three days. An unknown patient, after being quiet and withdrawn for a month, he became acutely ill on the day of emergency admission when he thought he had to die. He had heard the Death March being played for him. He had a compulsion to kill himself and this persisted in the ward. He left the ward much improved but a little earlier than we would have wished and declined day hospital or out-patient care because he was moving to Manchester

Two years later, after he had been abroad a lot, his doctor was suddenly called because he was beginning to get ill again. The doctor's assessment was that an urgent DV the following day would suffice. In the middle of the night he mutilated himself so extensively and badly with a razor blade that he was exsanguinated. At the last moment he did knock on his mother's door and asked her to call an ambulance.

The Coroner accepted that it was his intention to die (not just to do grievious bodily harm). He asked me, "Had he used the razor blade on somebody else and killed them, would it be your opinion that was of unsound mind?" I answered that "if he had been charged with murder it would be my opinion that he would be saved by the McNaughton Rules".

The Coroner then proceeded in his summing up to say that he was satisfied that the man intended to take his life but he was bound by a judgment of Lord Justice Devlin in implying that a man of unsound mind could neither formulate the intent to murder nor to take his own life, and he returned a verdict of undetermined death.

I had words with the Coroner, whom I know well, afterwards, and suggested that if the case went to appeal his verdict would be overturned. He went on to inform me that he and many Coroners were now recording a large number of undetermined verdicts (he suggested that they now exceeded, in his domain, the verdict of suicide) and he agreed that this was all very unfortunate as it would so distort suicide statistics. This is of importance if it is happening nationally; until now, in this country, suicide statistics had been one of the few hard data facts in psychiatry.

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Changes in the use of the Mental Health Act 1983 four years from its inception in Leeds Eastern Health Authority

DEAR SIRS

As a junior I was recommended the following guidelines, hopefully indicative of good practice within the spirit rather than the letter of the new Act.

1. *Emergency powers* should be used only for instances of dire necessity since there is no right of appeal and no treatment without consent. Such powers terminated by the second doctor should be a small proportion of the total, and should never be left to expire at 72 hours without the patient having had the benefit of a second medical opinion.

2. *Duration of detention* – the RMO should rescind the Section at the earliest opportunity rather than allowing it to expire. Having become informal, it would seem prudent to encourage the patient to remain in hospital before discharge to assess compliance and foster relationships not based on compulsion.

5. *Section 3* – powers lasting less than 28 days should be few.

To assess use of the Act in these areas at its inception and four years later, one hundred periods of detention from November 1983 were compared with another hundred from July 1987.