for child psychiatry and psychotherapy were on a sessional basis, not as a full-time attachment.

No one is going to offer any psychiatry tutor working in a District General Hospital another registrar's post to ensure ample numbers so as to give full six-month placements in all desirable settings.

We are going to have to try and ensure comprehensive training by attachments on a sessional basis to as many areas of psychiatric interest as is possible.

The College's demands for a fixed stereotyped three-year training programme is making our tasks very difficult, and we risk not being approved with posts losing recognition, just as a Local Elderly Mentally Infirm Unit is set up sixty miles from the nearest mental hospital, and fifty miles from the nearest psychogeriatrician.

Can the College not think afresh about the training of psychiatric junior staff in District General Hospitals Units, and would they not consider limited or partial approval for two years in such a setting where there is no mental hospital handy to complete the desirable three-year experience? Might posts not be approved, as in other specialties, rather than full programmes?

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College recognition of psychiatric tutors

DEAR SIR

The principles and criteria recently approved by Council (*Bulletin,* February 1982, **6,** 24) for the recognition of psychiatric tutors are welcome, but there are areas to which the College should give further thought:

1. In order that the interests of the majority of psychiatric patients are not disadvantaged, should there not also be a psychiatric tutor (specialty) in general adult psychiatry?
2. If the reports on trainees which the tutor is expected to prepare are of a written nature this should be indicated in the Statement on Approval which is sent to hospitals before Approval visits. Tutors and Approval Exercise Visitors in the past have disagreed on the practical interpretation of the present wording—that the tutor is 'responsible for collating the periodic assessment reports on trainees'. Many tutors and Approval Teams would also welcome comment from the College as to the form such reports should take.
3. Is not the amount of time to be allocated to the tutor best left for individual Divisions of Psychiatry to decide, on the basis of local arrangements and conditions? The document does acknowledge that tutorial duties vary between Regions but nevertheless states that 'a minimum of two sessions per week' should be allocated for tutorial duties. With consultants keen to participate in teaching and well motivated trainees, two sessions per week, for duties which are mostly of an organized nature, may seem unduly generous, particularly at times when there is any difficulty in meeting routine service commitments. In such circumstances there will be a natural increasing tendency to off-load teaching responsibilities on to the tutor because of his specific allocation of time for such. This would narrow the breadth of teaching experience to which trainees would be exposed.

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The College and South Africa

DEAR SIR

Dr Hemphill (*Bulletin,* March 1982, **6,** 44), like other white psychiatrists in South Africa before him (Gillis, 1977), chooses to ignore the main body of evidence in support of allegations of political abuses in the field of mental health there. Most of the evidence for political misuse of psychiatry in South Africa was summarized in my letter (*Bulletin,* November 1980, 171), and this was based on reports published by the World Health Organisation and the American Psychiatric Association. Apart from his ritual protestations, Dr Hemphill's attempt to discredit my motives and doubt the credibility of the accusations is not supported by any new facts.

His claim that South African mental health legislation is free of discriminatory provisions is irrelevant. It is also misleading, because he fails to mention that the apartheid system, under which all South African laws are enacted, is based on direct discrimination on the basis of skin colour alone. His suggestion that abuses do not exist because no one is authorized to misuse psychiatry is as credible as denying political bias in Soviet psychiatry because there are no laws in the Soviet Union which specifically invest psychiatrists with additional responsibilities to detain political dissenters in mental institutions. Dr Hemphill's naïve belief that practice of psychiatry, or for that matter medicine, could be free of prevailing social and political considerations can only be attributed to a refusal to recognize the realties of the apartheid system.

I referred to an article in the *Johannesburg Sunday Times* entitled 'Millions out of Madness' (27 April, 1975) because this was one of the first reports to accuse the minority government of a profit-incentive business deal with a private accountancy film, Smith, Mitchell and Company, which led to sub-standard care for black psychiatric patients. Miss de Villiers described the appalling conditions in mental institutions for blacks as 'a South African version of the Dickensian workhouse, an uncomfortable reminder of the bad days in Bedlam . . .'

If Dr Hemphill really believes that there is no differentiation in the standards of psychiatric care according to the

skin colour in South Africa, I must conclude that he has not visited any of the psychiatric facilities in Cape Town except for the all-white wards at Groote Schuur Hospital where he works. The main facilities for black patients situated at the Valkenburg Hospital are not only inferior in comparison to provisions for the white patients but fall far short of requirements in terms of basic human needs and rights. The male admission unit is a large, locked 'cuckoos nest' ward, with insufficient medical and other staff, dealing with up to six admissions a day. The units at Groote Schuur and William Slater Hospitals for whites have an eclectic range of treatments and a higher than average staff patient ratio, and are comparable to psychiatric facilities in teaching hospitals in the UK; whereas the 'black' and 'coloured' units at Valkenburg and Athlone Treatment Centre are characterized by isolation, inability to change and emphasis on detention and mainly 'organic' therapy. The full report of the APA Committee contains criticisms of the 'grossly inferior' medical and psychiatric care and a lack of basic essentials of habitations for blacks in most of the institutions they visited. The Committee's most shocking finding is the high number of 'needless deaths' among black patients in Smith, Mitchell and Company facilities. The Past President of APA, Dr Alan Stone's comment that all of the political and human injustices of apartheid are played out in the mental hospital system was based on first-hand experience.

Dr Hemphill has also left out any mention of professional concern for the long-term psychological ill-effects of the apartheid system. The rising suicide rate among young blacks (Meer, 1976), psychosocial deprivation and stresses following the unnecessary disruption of families (Taitt, 1980), and the consequences of living in segregated, squalid single men's compounds must surely concern any psychiatrists, especially those working in Cape Town where the MRC Social Psychiatry Unit is attached.

Dr Hemphill implies that I have no right to comment on South African psychiatry because I have had no personal experience of it and am not acquainted with South African mental health legislation. He, of course, does not mention that it is difficult for psychiatrists like me to gain acceptance there—in the whole of South Africa there is only one black psychiatrist (Dommisse jr, 1981): and the experience of psychiatry for most non-whites in that country is as recipients of substandard care. Furthermore, as a member of a privileged minority which stands to lose its position of advantage if the *status quo* is threatened, his assertions are more likely to be biased and ill-informed.

Dr Levine's reply on behalf of the Special Committee on Political Abuses of Psychiatry in the same issue of the *Bulletin* must be welcomed for its fresh appraisal of the Committee's remit. The Committee's acceptance of a rigid and narrow definition of 'political abuse', based almost exclusively on the Soviet example, had, in the past, prevented it from fulfilling its functions. The fact that it has taken more than five years for the Royal College to officially recognize the allegations against South African psychiatry is an example of this failure. If, as Dr Levine suggests, the Committee is prepared to consider all forms of abuses of psychiatric standards and practices which result from contamination by political oppression, irrespective of the political ideology behind it, they must be supported. This change in emphasis will not only be seen as a reflection of the College's active but unbiased concern in such issues, but will render the Committee's efforts more meaningful.

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Medical abdicationism

DEAR SIR

Dr Alexander Walk in his letter to the *Bulletin* (February 1982) cites an extreme example of 'medical abdicationism'. I find myself increasingly concerned by the paralysing effects of multidisciplinary management in the Health Service. Although I personally favour the trend towards professional autonomy, it seems that this is usually interpreted as professional equality, with those who have been trained to provide leadership, and are financially rewarded commensurate with this responsibility, largely unable to function in a leadership role. The resulting management by committee leads to a tendency to maintain equilibrium as a balance of equal forces. There is little room within this system for individual initiative experimentation, vision or charismatic leadership.

An excessive preoccupation with safety and compromise reduces the risk-taking to a minimum and leads to procrastination, buck-passing and generalized mediocrity. The failure of any one discipline to allow any other jurisdiction over its professional boundaries leads to fragmentation and a failure to plan service development in its widest sense.

In the absence of a coherent lead from above, staff within sub-units of the system bury themselves in the minutiae of their units not having been given the degree of autonomy necessary to institute their own salvation (and that of their patients!).

The paradox is surely that it is only through strong leadership that true autonomy, respect and mutual tolerance