

remove her forcibly from the hospital. Fellow consultants, the Mental Health Act Commission, hospital managers and trust solicitors agreed that the patient's best interests were paramount, but were unable to give practical advice. We decided that she should not have leave at that time, and the wedding was postponed with her agreement.

Were we ethically and legally justified in preventing her marriage as her decision to marry (we assume) was made when she was well? Had she married, could her illness become the basis for later annulment?

Miss A's fiancé subsequently agreed for her to be detained under section 3 of MHA. She was treated with ECT, to which she responded, but remained a high suicide risk in the early stages of treatment. In spite of thoroughly and repeatedly explaining the severity of her illness to her fiancé, he was party to her repeated removal from hospital. Only the threat of legal action was sufficient to prevent this and to allow her to receive treatment. He was fully informed of his rights to apply for her discharge but did not pursue this. He appealed to hospital managers who upheld the section. She eventually recovered, was discharged and now attends the day hospital, where she is reported to be well.

To treat disturbed patients without the full co-operation of relatives is difficult, but to anticipate and manage surreptitious attempts to remove patients from hospital illegally poses special problems. What other steps might be taken to prevent the removal of the vulnerable from hospital? Have other readers found themselves in similar circumstances? We welcome comments on the legal issues raised and suggestions as to how best to resolve such problems.

K. SILLIFANT, J. M. O'DWYER and R. H. S. MINDHAM,
*Leeds Community & Mental Health Services,
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Supervision registers

Sir: I am writing this letter about this matter after a thought-provoking talk given at the College's recent East Anglian meeting.

It was made apparent that the Department of Health would not budge from their decision to implement these registers. In some areas there are over 200 patients on the register already.

The Department of Health has given its overall guidelines and criteria for placing patients on these registers. It may be a good idea for the College to develop its own operational criteria so there are no ambiguities in the minds of psychiatrists or vague interpretations in coroner's and courts of law when tragedies occur. In this way the College would determine good practice and there would be no other use of these registers except clinical and patient care. Similarly, there should be withdrawal operational criteria which would benefit patients and doctors alike.

To help in this, a brief depression and suicide risk questionnaire may help. Like all operational criteria these would not be perfect but one can review and audit them regularly.

M. A. MAKHDUM, *Turner Village Hospital,
Colchester, Essex*

Communication between GPs and psychiatrists (or communication between psychiatrists and GPs!)

Sir: The article by Prakash Naik & Alan Lee (*Psychiatric Bulletin*, 1994, 18, 480-482) highlights not only, as they mention, "problems in communication between hospitals and GPs" but also the difficulties experienced by those in secondary care trying to influence the behaviour of their colleagues in primary care. Such difficulties also apply to GPs trying to influence behaviour of hospital staff.

Closer understanding of GPs' working patterns, roles and responsibilities by secondary care staff is required if progress is to be made towards resolving such 'problems in communication'. One step forward would be an increase in the number of psychiatric trainees doing attachments in general practice (Burns *et al*, 1994). Likewise, GP insight into the working of the psychiatric team is vital.

GPs receive a large amount of mail daily (the 'thud factor'). It is impractical for them to absorb and then implement all requests received. Perhaps, as the authors themselves hypothesise, a telephone or personal contact would have had more impact of referrers' behaviour than a ten page guide or letter? Prospectively it would be interesting if the authors met at least some of the GPs

concerned to find out why the GPs felt that two written communications had made so little difference to their practice.

When auditing process, unless all parties who have a direct influence on the outcome of that process are included in the audit mechanism (GPs in this case), changing performance (improving referral information) may prove elusive.

Naik & Lee's article reinforces the need to develop both face to face multiprofessional communication and audit which crosses the perceived 'wall' between primary and secondary care. Using such an approach, there is more chance of improved clinical practice.

BURNS, T., SILVER, T., FREELING, P., & CRISP, A. (1994) General practice training for psychiatrists. *Psychiatric Bulletin*, 18, 286-288.

SIMON BALMER, *Wakefield Healthcare, White Rose House, West Parade, Wakefield WF1 1LT*

Sir: We agree with Simon Balmer. We forgot to say that a general practitioner helped to design the audit. This lapse may be an example of the partly unconscious barriers that Simon Balmer describes. We do meet and talk fairly often with our GPs. We avoided mentioning the items we were measuring in the interests of science. More recently we have often suggested letters might be sent to the base, and might include more information, but most still arrive after some delay, at the hospital, and some are still highly condensed. Old habits may die hard, especially in the face of modern pressures. However, Simon Balmer's reminder to include all parties that affect outcomes in the audit process is very well taken.

ALAN LEE, *University Hospital, Nottingham NE7 2UH*; and PRAKASH NAIK, *Lyndon Resource Centre, Hobs Meadow, Solihull, West Midlands B92 8PW*

Buddhist meditation

Sir: Dr Dwivedi gives an interesting account of the relationship between Buddhist meditation and contemporary psychotherapy (*Psychiatric Bulletin*, 1994, 18, 503-504). However I think he gives an overly negative impression of Buddhism. He describes the five precepts in their negative form for example refraining from stealing and lying. In their positive form these

are practising generosity and truthfulness. The cultivation of these positive counterparts are probably a more important focus for those who wish to practise Buddhist ethics.

As well as meditation on breathing the Buddha taught the 'metta bhavana' or development of loving kindness (*Metta Sutta*, 1985). The cultivation of metta provides an emotionally positive balance to the meditation on breathing. Dr Dwivedi refers to the famous analogy with the ocean: Just as the ocean has one taste the taste of salt so the Buddhist teaching has not the taste of renunciation, but rather the taste of vimutti, which is release, or freedom (*Udana*, verse 56, 1985). Renunciation is an aspect of the Buddhist path, but the purpose is to find freedom, especially freedom from suffering.

The importance of understanding the positive nature of Buddhism is threefold. First many Westerners may have a materialistic, nihilistic conditioning which will tend to lead to a misinterpretation of Buddhism as a nihilistic (and therefore unattractive) religion. Secondly, the meditation on breathing practised on its own without also cultivating positive emotions can lead to adverse psychological effects. In particular, it may lead to an exaggeration of neurotic defences such as intellectualisation and reaction formation to dissociate from ego-dystonic emotions (Epstein & Leif, 1981). Thirdly, in order to gain 'insight' not only is a concentrated mind required but also one flexible and refined through being 'soaked' in emotional positivity (jhana). The final goal of enlightenment includes wisdom (panna) which is conjoined with compassion (karuna) to help other sentient beings.

EPSTEIN, M. & LEIF, J. D. (1981) Psychiatric complications of meditation practice. *Journal of Transpersonal Psychology*, 13, 137-147.

Metta Sutta. In *Sutta-Nipata*. Translation by Saddhatissa, H. (1985) London: Curzon.

Udana. Verses of Uplift. In *The Minor Anthologies of the Pali Canon*, Part II. Translation by Woodward, F.L. (1985) London: Pali Text Society.

PARAMABANDHU GROVES, *National Addiction Centre, Addiction Sciences Building, 4 Windsor Walk, London SE5 8AF*

Sir: Thank you for asking me to respond to Dr Groves' letter. Buddha taught many techniques of meditation and suited his teachings to the needs of the individuals. As