identified general and old age JPAC quotas. It is necessary to monitor posts that come 'on the market' and the departures that release them on an annual basis – so that training opportunities can be modified in response to actual as opposed to planned need.

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Reference

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Psychiatry and the private sector

DEAR SIRS

As a consultant psychiatrist, working in one of the more notoriously deprived inner London boroughs, I was saddened at Dr Birley's response to the open letter objecting to a session on Private Psychiatry at the Autumn Quarterly Meeting (*Psychiatric Bulletin*, December 1988, **12**, 554). The key points made by the letter's signatories were the non-academic aspects of the topic, the promotional interests of some of the speakers, and the NHS as "the only option for the vast majority of our patients". To reply with unnecessary defensiveness, that "private care is a legitimate business" – whoever said it was not? – and that it "makes a contribution to the care of our citizens" is banal and beside the point.

The key question is whether private practice, *per se*, has any particular academic contribution to make to psychiatry that cannot be, or is not being, made in the NHS. The subsidiary, but equally vital, point is the economic status of those suffering from significant mental illness which by definition largely puts them out of reach of private care. This is not a "matter of debate" but an established aspect of social psychiatric research.

What I find so annoying about modern private psychiatry is the false hope and guilt engendered in patients and relatives, who fear that if they just paid enough money a chronic schizophrenic illness would somehow be resolved. Those unable to think clearly or judge appropriately, because of illness, are especially vulnerable to such notions. Yet never once has a private practitioner contacted me or my colleagues for a detailed background history of patients well-known to us, yet referred by, for example, an inexperienced GP or GP locum.

In my experience the main contribution of those working in the private sector has been despair, not care. The contrast between the crumbling Victorian infirmary in which I write and the glossy brochures of new private hospitals is especially discomforting. Were they to consider researching such aspects of the outcome of private referral, I might be prepared to listen to their presentations.

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DEAR SIRS

As one who has for many years worked solely as a private practitioner in psychiatry, I can still have some sympathy with and understanding of the concern expressed by Appleby *et al* (*Psychiatric Bulletin*, December 1988), although I feel that their expression of it does not really reflect the basis for their distaste and is a little inappropriate.

It must surely be agreed that the prime objective of psychiatry (as indeed of all other branches of medicare) is to provide the best possible service to the patient. The method of remuneration should be immaterial. Thus psychiatry in private practice is in general not characterised by problems that do not arise in any other community-based service and as such is not a separate academic discipline. However, the same is true of practice in a Government service.

The consideration of the nature and funding of services and their impact on treatment is a legitimate object of scientific study and in psychiatry dates from the time of Freud.

Any sessions that meet this criterion will not affect either our academic reputation or our ethical one.

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A medical member's analysis of 50 patients at the Mental Health Review Tribunal

DEAR SIRS

As a medical member of the Mental Health Review Tribunal (MHRT) for Yorkshire, I have analysed a series of 50 consecutive cases that I have examined in the four-year period 1985 to 1988.

Findings

Sex: There were 26 men and 24 women, total 50.

Age ranges: Twenty-two (15 men, seven women) were in the 20 to 35 age range, including 14 (nine men, five women) aged 26 to 30. Seven (four men, three women) were in the 36 to 40 age group. Twenty-one (seven men, 14 women) were aged from 41 to 85, including one woman in the 66 to 70 age group, one woman 71 to 75 and one woman 81 to 85.

Section of Detention under the Mental Health Act 1983: 26 (14 men, 12 women) were detained under Section 2, 16 (five men, 11 women) under Section 3, and eight (seven men, one woman) under Sections 37/41 (restricted patients).

Diagnoses: Twelve (four men, eight women) were suffering from schizophrenia; 17 (ten men, seven women) paranoid schizophrenia; 16 (seven men, nine women) manic depressive psychosis; two men psychopathic disorder and three men mental impairment.

Outcome: In 40 cases (20 men, 20 women) the patients were not discharged. In two (one man, one woman) a decision was deferred. One man was granted trial leave. Five (two men, three women) were absolutely discharged and two men were conditionally discharged.

Observations: There was a preponderance of patients (14/50) in the 26 to 30 age group. Section 2 cases accounted for about half (26/50) of the total. No restricted patients were aged over 45. Far more restricted patients were male than female (ratio 7:1). Schizophrenia and paranoid schizophrenia together were nearly twice as frequent as manic depressive psychosis. Cases of manic depressive psychosis were more frequently discharged than patients with other diagnoses.

Some of the results were predictable, others less so. Compared with the schizophrenias, manic depressive illness can run a cyclical course with acute exacerbations and rapid improvements. This would account for more manic depressive patients being under the short term order, Section 2, and being more likely to gain discharge. On the other hand, the schizophrenias, running a longer and less rapidly fluctuating course, were more frequently detained under Section 3. Paranoid patients might be more likely to seek redress of their status through the Tribunal. One in seven cases was absolutely discharged or conditionally discharged and this discharge rate of around 15% is near average for regions without a special hospital.

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Schizophrenia in ethnic minorities

DEAR SIRS

The question of schizophrenia in ethnic minorities in Britain has been the subject of recent publications and a leading article in the *BMJ*. Since there is some unease about the content of these reports and their impact on medical and lay audiences, the Executive Committee of the Transcultural Psychiatry Society (UK), of which I am the current Chairperson, has agreed the following statement:

(1) Schizophrenia as a concept used in medical circles to denote an illness is as much socially constructed as it is biologically determined. In the present state of social and medical knowledge, the diagnosis of schizophrenia tells us as much about the biases in our society and in the person making the diagnosis, as it does about the 'patient'.

(2) The effects of research published in scientific journals must take into account the prevailing political context. It is naive to assume that research on issues involving race are value free when conducted in a racist society, within a discipline, such as psychiatry, with a powerful racist tradition.

(3) While accepting that schizophrenia is diagnosed to a relatively disproportionate extent among black people in the United Kingdom, we deplore the impression that may have been given in some recent publications that this fact reflects a biological inferiority of Blacks in comparison to Whites. In particular, we are concerned to hear that these reports may lead to studies which concentrate on genetics of black people to the exclusion of other issues and/or the investigation of possible virus infections being carried by Blacks. We believe that such studies will have seriously damaging political implications for black people in this country in the present political context of racism while any conclusions drawn from such research are likely to be, at best, of very limited use, and, at worst, extremely misleading, given the present state of knowledge in psychiatry.

(*end of agreed statement*)

Everyone recognises the fact that the advancement of knowledge needs a 'free press' for the reporting of findings and observations that are useful – and this applies to psychiatric journals as much as to others. However, it is naive to assume that researchers are unaffected by social and political pressures and attitudes, and, it is unrealistic to view published reports as devoid of political influence. In fact, conclusions arrived at in a subject like psychiatry where objectivity in measurement is uncertain often represent (to some extent at least) preconceptions of researchers. And tentative reports and hypotheses once reported in print may be used to reinforce popular misconceptions.

I believe that, in a society like ours that is far from perfect, the value of any particular publication must be seen in terms of a balance of pros and cons seen on a wide canvas. We have seen how the writings of psychologists in the 1930s provided nourishment to the eugenic movement and the rise of Nazism. The revival of this 'racist IQ movement' in the 1970s is still very much alive and we may now be entering the age of the 'new eugenics' (Kevles, 1986). I believe that papers, such as that by Harrison *et al* (1988) published in *Psychological Medicine*, are potentially as dangerous in this day and age as the paper by Jensen (1969) that led to 'linkage of IQ and educational policy with race' (Kevles, 1986) – with resulting grave disadvantage to black Americans. The dangers are only too evident in the press report of the Harrison paper headlined 'Young blacks vulnerable to schizophrenia' (Ballantyne, 1988).