CORRESPONDENCE

ANNUAL MEETINGS RECALLED

DEAR SIR,

I am sure that many others besides those who belong to the 'Geriatric Group', as I do, will join me in their appreciation of these articles and in hoping that they will be continued.

I have a special, perhaps parochial, interest in the 1877 Annual Meeting, recalled in the October issue. The President in that year, George Fielding Blandford was Lecturer in Psychological Medicine at St George's Hospital Medical School for 37 years, from 1865 to 1902, and the President-Elect, James Crichton-Browne was Lord Chancellor's Visitor for 47 years, from 1875 to 1922. So they were both predecessors of mine.

Dr Blandford elaborated his lectures to students into a best-selling textbook, and readers may be interested in the 'vocational guidance' which he there gave to those who came of what he called 'tainted insane stock'. He strongly recommended that they should take 'a government post' because 'the hours are light, the responsibility not formidable, the holidays long'—in contrast to the hard work and responsibility involved in medicine and the law.

Since Dr Walk's articles recall Silver Jubilees as well as centenaries I look forward, should we both survive, to his account of the somewhat turbulent Annual Meeting of 1964, when, as the last event of my Presidency, the decision was taken to form a Royal College.

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THE PSYCHIATRIST'S RESPONSIBILITIES

DEAR SIR,

May I draw attention to a serious misconception which underlies the current debate on clinical responsibility and multi-disciplinary teams—namely the tendency to regard the situations in mental handicap and general psychiatry as identical and to extrapolate from the one to the other.

In fact they are quite different. The essential problem in mental handicap is the recent recognition that the present service model is no longer appropriate, and many of the present trends in the organization and running of services, particularly of mental handicap hospitals, are interim strategies—ways of trying to provide an improved service within an outdated system. Admittedly this has given rise to problems of roles and relationships between the involved professions, but these are more logically solved by changing the system of care than by attempting an expedient redefinition of roles.

To be more specific, the consultant in mental handicap finds himself responsible for a large number of individuals whose primary needs are social and educational rather than medical, and must of necessity acknowledge his own limitations in the contribution he can make to their care, whilst at the same time accepting his traditional responsibilities for those who are still officially his patients. Once more appropriate facilities have been developed for these people there can be no confusion about the doctor's role, for he will retain responsibility only for those presenting primarily with medical or psychiatric problems.

The conflict in general psychiatry is much more a genuine power struggle between the professions involved in the care of the mentally ill, and in this I stand firmly with my psychiatrist colleagues in the support of the primacy of the doctor. Until the two issues are clearly separated productive debate will be impossible and arguments will continue to be advanced from false premises. It is no more legitimate for the doctor to claim clinical authority over all residents in mental handicap hospitals on the basis of sound arguments in favour of medical primacy in general psychiatry than it is for psychologists and others to use the unique situation of mental handicap to further their claims in general psychiatry.

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Dear Sir,

The formulation of College policy (*Bulletin*, September 1977) will surely remain of great value for a long time in the study of this area, which is often so difficult to define. However, in paragraph 10 (p 4) of *The Responsibilities of Consultants in Psychiatry within the National Health Service*, there is an exaggeration of the power and the responsibility which we have. The statement 'Thus he decides whether the patient should receive in-patient, out-patient or day care

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and will admit or discharge patients as appropriate', should surely read 'Thus he decides, in the case of informal patients, whether they be offered in-patient' out-patient or day care and will offer admission or decide on discharge'.

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THE WARLINGHAM PARK INQUIRY

DEAR SIR,

Dr Glaister's attempt to demonstrate that all is for the best in the best of all possible worlds at Warlingham Park (*Bulletin*, August 1977) is weakened by a strange misunderstanding of statistical argument. He says that 'any *post-hoc* selection of periods to compare runs the risk of arbitrariness'. Agreed, but this selection also vitiates the logic of his null hypothesis. Since he chooses those years in which there have been few suicides to compare against the periods before and after, χ^2 of course shows that this distribution could not arise by chance, but the calculation is redundant, since he has selected his distribution and *ipso facto* it is non-random.

If instead one works on the null hypothesis that there is no difference in the rate over time, and divides the period 1961 to 1975 into three-year blocks (to allow expected cells of sufficient size χ^2) the expected number of suicides for each block can be calculated from the total number and the population at risk for each year.

Even using the most generous assumption that suicide rate is more likely to be related to the admission rate than the total hospital population, the differences between the three-year blocks from 1961 to 1972 could arise by chance alone ($P > \cdot 05$). If years 1972–75 are included, the probability of the increase being a chance variation is less than $\cdot 001$. Only if there were criteria other than the suicide rate to determine Dr Glaister's division of these years into three periods would his analysis and inferences be valid.

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NEWS ITEMS

A PSYCHIATRIC CHARITABLE TRUST

Just over five years ago the first psychiatric charity to be formed since the inception of the National Health Service was created at Toft Hall, Knutsford, Cheshire, under the heading of The Society for the Investigation of Human Values. This Charitable Trust was established to fulfil two main purposes; the first was to carry out psychotherapy on a personal and individual basis; the second an educational one, providing regular seminars, lectures and courses on all aspects of human behaviour and human relationships. The Society is under the directorship of Dr W. V. Wadsworth who, until the founding of the Society by himself and his wife, was for the previous twenty years Superintendent of Cheadle Royal Hospital.

The Society has now been able to effect the purchase of the freehold of Toft Hall. Although the great advantage of treating as many people as possible on an out-patient basis has throughout been recognized, it has become clear that the provision of a small number of beds would be desirable, and Toft Hall has now been registered as a Private Nursing Home capable of admitting up to fourteen residential patients.

One of the special features of the Centre is the psychotherapeutic facilities for married couples suffering from emotional disorders, arising from relational and communicational difficulties. The Centre also treats patients suffering from all types of psychoneurotic anxiety and depressive states, phobic and compulsive disorders, and patients with alcoholic problems not likely to suffer from withdrawal symptoms.

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