

BRITISH MEDICAL JOURNAL

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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

The psychiatrically disabled

SIR,—1981 is, of course, the International Year of the Disabled and has already received considerable coverage in the media. So far, however, the emphasis has been entirely on the physically disabled and mentally handicapped, with no mention of the very large group of people who are permanently disabled by psychiatric illness.

This invisibility of the psychiatrically disabled is not a new phenomenon and may be a consequence of their less attractive public image. Whereas society can comfortably, if condescendingly, regard the physically disabled as brave, cheerful, and wonderful, the psychiatrically disabled individual is seldom cheerful and not obviously either brave or wonderful.

Psychiatric rehabilitation receives similarly scant attention from those involved in research, the allocation of resources, and the training of psychiatrists and other personnel. A recent report from the Royal College of Psychiatrists¹ recommended the creation of more training posts in rehabilitation, but present government policies suggest that the major burden of disability will continue to be carried by relatives supported by community care facilities. Some inclusion in the consciousness raising impetus of the Year of the Disabled would provide welcome recognition for the efforts of those engaged in this potentially rewarding but often unexciting and life-long task. It might also provide an atmosphere in

which recruitment could be improved and funding increased.

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¹ Royal College of Psychiatrists. *Psychiatric rehabilitation in the 1980s*. London: Royal College of Psychiatrists, 1980.

Messages from non-medical authors

SIR,—Over the last year or so I have been considerably impressed by three papers published in the *British Medical Journal* and contributed by non-medical authors.¹⁻³ They dealt with death, dying, and serious suicidal impulse, and all pointed with sorrow as well as in evident anger to perceived inadequacies in the medical care or administrative handling of their distressing cases. We know from studies of the dying⁴ and the bereaved⁵ that anger directed outwards and particularly towards doctors is a frequent manifestation of distress in patients and their relatives when confronted by death. Yet I believe that the messages contained in these papers are of greater significance to doctors and their educators than as poignant examples of projective mechanisms of defence. Likewise I am sure that we should not fail to receive these messages simply because we are growing impatient with raucous antimedical

voices in the popular media. These papers are constructive and are aimed at a medical audience.

The paper that appeared on 3 January, by Wendy Valerie Harmon,¹ details the insensitive administrative decisions which were taken in hospital following the cot death of her infant. In addition to their immediate grief, the writer and her husband had to suffer unnecessarily prolonged and harrowing experiences in connection with seeing their child and documentation of the death. Only the young hospital doctor who saw the couple at first emerges with credit.

The most remarkable article is perhaps that by Roger Carus,² a young civil engineer dying of motor neurone disease. Not only administrative delays but also the communication failures of the hospital doctors and their preoccupation with diagnosis to the exclusion of care are pinpointed for criticism. His general practitioner is praised for continuing to call, but the message is clear that coping with his predicament was a matter for the patient and his family, with little practical help forthcoming from the Health Services.

Each of these authors refers positively to the self-help organisations which are developing in response to these unmet emotional and practical needs of patients. As doctors we should applaud the work of these organisations but deplore the circumstances which have led to their development.

The third story, written anonymously, is startling; but at least it has a happy ending.³