

the living conditions of children in the poorer sections of the community and have little idea of the adversity over which these children triumphed. If they plan to return to India, rather than remain in the West, I will gladly show them the areas where our study was conducted.

Mirza's account of child psychiatry provision is rather misleading. Shortly after we arrived, one excellent psychiatrist started a child guidance clinic in the Government Mental Hospital for one morning per week. This served a district with a population of 2.5 million. His comments on "harsh religious indoctrination" are his, not ours. We felt that the mosque provided an important source of social cohesion that served to protect children from psychological disturbance.

Your correspondents are coy about their own exposure to the community in and around Calicut. In this connection it is worth pointing out that I have spent 31 years (out of 39) living there, so my familiarity with the area is more than just passing. Babu & Michael are wrong to call our study transcultural; it was rigorously conducted using standard epidemiological techniques. Of course, a descriptive account such as our article will involve the selection of material, as any intelligent reader would understand, but we reported only what we saw. What seems to have eluded Babu & Michael and Mirza are the implications of the statistics that they themselves quote. What makes Kerala's achievements in health and education so monumental (our psychologist found 98% literacy by the age of 12) and its reputation as a model of development for the rest of the world so richly deserved, is that it has been achieved in the face of exactly the kind of material deprivation we described in the article. If they have failed to see it, maybe it was because they did not want to.

I am saddened that their approach has been one of hostility rather than interest. As well as conducting a study that would ultimately benefit the local community, our mission during the fieldwork was always to encourage research and critical thought among our local colleagues. I would have been only too happy to discuss our data with them, had they been interested.

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### **'Passing the buck' – A valid use of Mental Health Review Tribunals?**

Sir: Responsible medical officers not infrequently have to make difficult decisions to determine whether patients detained under 'section' are ready for discharge. In particular, uncertainties arise in trying to predict whether patients may

pose risks to themselves or others. In our experience, most of these difficulties tend to occur firstly with patients whose problems have a degree of chronicity, a history of serious harm to themselves or others and demonstrate the ambiguities sometimes associated with a classification of psychopathic disorder and secondly, with acutely manic patients (Wilkinson & Sharpe, 1993). Mistaken decisions to discharge have sometimes had tragic consequences which, besides adversely affecting the patient or others, have had direct repercussions on the consultant.

Outcome studies of patients discharged by Mental Health Review Tribunals (MHRTs) are limited in numbers of patients and duration of follow-up (Spencer, 1992; Wilkinson & Sharpe, 1993; McKenzie & Waddington, 1994). Nevertheless, a particular manoeuvre which the responsible medical officer sometimes employs when faced with difficult decisions about discharge is to await the patient's application or reference to a MHRT. If his report is not unfavourable to the patient's discharge, the MHRT may discharge him or her. The consultant will then have averted taking responsibility for the decision. MHRTs are well aware of this phenomenon but their attitudes to it vary. They may see it either as 'buck passing', in which the consultant does not fulfil his or her responsibilities, or as a valid and appropriate tactic in particularly difficult cases where questions of diagnosis or prediction, or both, are uncertain and decisions are made by a small group especially appointed for the purpose and backed by authority. The lack of personal involvement of the medical member in particular will help his objectivity and his intermediate position between the carers and the lawyers can be to the advantage of both. He will bring his clinical experience and skills to bear but most of all will be able to apply a medical mind to a critical review of the evidence and opinions as presented (Langley, 1993).

We should be very interested to hear the opinions of other psychiatrists, particularly members of MHRTs. We feel that, with the increase in adverse publicity and possible litigation resulting from psychiatric miscalculations, the phenomenon we describe may well increase in frequency.

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