made for hospital care for these categories of patients.

From the beginning, the Basaglia plan has been vigorously supported by the Communist Party—for their own political reasons. It may be noted that the Basaglia form of psychiatry does not in the least resemble the form practised in the Soviet Union and other Communist countries, which adheres firmly to a hospital-based system and an organic aetiology for chronic schizophrenia. On the other hand, the Italian Communist Party is somewhat different from the Russian party. Initially, many of the other Italian political parties supported the new law, but following the uproar from anguished relatives and a large number of psychiatrists, they now are all, except for the Communist Party, attempting to amend the law in various major ways. A law in draft, to establish a new network of Centres for Treatment and Rehabilitation, where patients can stay for up to six months, has widespread popular, political and medical support. However, a major difficulty is posed by the fact that there are few facilities existent to locate these centres; the space freed in the old hospitals by the mass expulsion of the patients has been largely filled by schools, social work facilities, small apartments for patients, or the buildings are simply falling down through lack of maintenance. Moreover, there is little money available to finance these new centres.

An Italian colleague in academic psychiatry estimated that some 60 per cent of Italian psychiatrists today strongly oppose the Basaglia system, some 20 per cent are passionately in favour of it, and some 20 per cent are neutral. These divisions follow closely the political persuasion of the protagonists. However, it must be noted that the Italian Psychiatric Association is strongly influenced by Basaglia's followers. It is not unusual for fanatical followers of a minority cult to infiltrate official bodies in this way.

There are, however, some positive features about the Basaglia plan. The atmosphere in the large hospital in Venice that I visited was very pleasant, with 150 patients living as guests in its various palazzos. The emotional impact was one of warmth, tolerance and almost gaiety. All the patients had no family to go to or did not wish to leave the hospital which had been their home for many years. One could not help being impressed likewise with the dynamic enthusiasm and personal warmth that the young staff psychiatrists bring to their task of social revolution. Unfortunately, all the dedication, enthusiasm and emotional warmth in the world cannot remedy the fact that schizophrenia is a catastrophic illness and not a way of life or a psychosocial reaction to 'authoritarianism, hierarchy, and inflexibility'. Many schizophrenics *must* be treated in hospital for more than forty-eight hours (renewable to fourteen days). Many schizophrenics *never* recover to the extent that they can ever live, even in semi-supervised apartments, and are in need of the long-term care that the much maligned word 'asylum' used to entail. But there is surely no earthly reason why this care, enthusiasm and warmth cannot be lavished on patients in a medium-stay hospital as much as in a fourteen-day stay hospital. Certainly no one would wish to return to the bad old days when psychiatric hospitals were almost indistinguishable from prisons. But the chronic mentally ill deserve better (and not only in Italy) than their present fate decreed by budget cuts grafted onto the lingering effects of the outworn sociological dogmas of the 1960s. It could be argued that the mentally ill were treated better, in some respects, in the United States and England of the 1870s after the reforms led by the Tukes and by Dorthea Dix, than they are treated today.

The conclusions drawn by Jones and Poletti[3] following their visit to Italy are very similar to those I present in this paper. In fact, the picture they painted was even grimmer, since they visited the south of Italy where conditions are even more appalling than in the north. They accuse the British supporters of Psichiatria Democratica of tunnel vision, unfamiliarity with the different culture, inability to sift propaganda from truth in the claims made by Psichiatria Democratica and from the usual English response to a sudden immersion in romantic Italy. Furthermore, Jones and Poletti[3] state that this romantic fictionalized version of the 'Italian experience' put about by its supporters in England is being used as a lever for change 'with the implication that mental hospitals can be abolished in England without extensive and expensive substitutes, that patients can be reabsorbed into the community without pain or effort. The real lesson is that this has been tried in Italy, and it has failed . . .' This is a conclusion that I strongly support as a result of my own investigations. One is reminded of the remarkable fact that people as intelligent as Sydney and Beatrice Webb were deluded into claiming in their book, *Soviet Communism: A New Civilization*, that the political system of the Soviet Union represents a great advance for good in the human condition. It will be recalled that their eccentric conclusions were based on an examination of the Soviet Constitution as *written*, which, by this time, as everyone knows, bears not the slightest resemblance to the facts of Soviet political life. Likewise the propaganda put out by supporters of Psichiatria Democratica bears only a tenuous relationship to the facts of how psychiatric patients fare in Italy today.

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The Samaritans branch psychiatrists

DEAR SIRS

Recently I have spoken to some other Samaritans branch psychiatrists and we feel that it would be useful to convene a meeting of branch psychiatrists to discuss aspects of the work

which we do with the Samaritans. I have discussed this with Dr J. L. T. Birley, who is the medical consultant to the Samaritans, and he agrees with me that it would be useful to organize a meeting which would take place at about the same time as a quarterly meeting of the College.

It would be an informal meeting and as such we cannot expect it to be included in the already busy programme of section, group and other business meetings which are held between the formal sessions of a quarterly meeting. What is proposed is a meeting which would take place on the afternoon or evening before a quarterly meeting or on the evening or morning after a quarterly meeting.

Since there will be a session on parasuicide at the Autumn Quarterly Meeting to be held in London on 14 and 15 November 1985 this might be the most appropriate opportunity, but we could meet at the time of one of the other meetings. If other branch psychiatrists are interested, I would be grateful if they would let me know.

KEITH J. B. RIX

St James's University Hospital
Leeds

The 'Ivory Tower' vs. 'the poor nation of others'

DEAR SIRS

I read with interest Professor Goldberg's comments on my article (*Bulletin*, April 1985, **9**, 83) and his statistical 'evidence' that the University Hospital of South Manchester relatively gives better patient care, with less resources, to a larger population than Prestwich Hospital, while at the same time it conducts far more teaching and research. The inevitable conclusion from this paradox, Professor Goldberg would no doubt have us believe, must lie in the superior intrinsic quality of his academic staff; and this is, indeed, the issue I wish to contest, i.e. the widely held but erroneous view that academic excellence implies, as if by definition, good patient care.

While agreeing with Professor Goldberg that the two terms are not contradictory, I maintain they are distinct and not interchangeable, e.g. asking for money for patient care when you want money for research. The advantage really lies where resources go and patient care should, certainly more often, be given priority.

VICTOR S. NEHAMA

Prestwich Hospital
Manchester

DEAR SIRS

Without wishing to be too pedantic, or to prolong the argument, I feel that I must comment on Professor Goldberg's assertion (*Bulletin*, April 1985, **9**, 83) that the Ivory Tower in Manchester undertakes equal or greater patient care compared with the 'poor nation of others'.

As any researcher will know, we must compare like with like and a more accurate comparison would be, Ivory Tower DGH versus North West Peripheral DGH. Professor Goldberg is well aware of the results of that analysis.

In addition, Professor Goldberg's assertion that 45 per cent of his referrals come from outside the catchment area is well covered by the funding of several Regional Units at his hospital. Our own District's figure of 33 per cent from outside the catchment area is covered by no such Regional funding.

MICHAEL A. LAUNER

Burnley General Hospital
Burnley, Lancs.

[We invited Professor Goldberg to reply—Eds.]

DEAR SIRS

My letter was not intended as a criticism of my colleagues at Prestwich Hospital, but merely as a defence against Dr Nehama's original suggestion (now withdrawn: thank you) that there is some necessary antithesis between academic psychiatry and patient care. I quoted a few figures to make the point that we do not lean on our spades where clinical work is concerned, and I am very pleased that Dr Tarsh has, on behalf of his colleagues, publically disassociated himself from Dr Nehama's original article by acknowledging that we do 'do a very large amount of excellent clinical work' (*Bulletin*, June 1985, **9**, 122).

I may have annoyed my consultant colleagues at Prestwich by drawing attention to the fact that they are not under-resourced. Dr Tarsh now writes that resources being spent on us should be spent in areas from which our patients originate: this is of course already being done, and in the long run it will hurt Salford perhaps even more than South Manchester.

I have considerable sympathy with Dr Launer's letter. Of course I am 'well aware of the results of that analysis', since I was responsible for actually carrying it out.[1] The standard DGH model service is seriously under-resourced in terms of total medical staff, nursing staff and 'other therapists', and it is therefore cheaper than ours, and very much cheaper than services based upon the mental hospital.

Your correspondents are all wide of the mark concerning patients attracted into the teaching area. Dr Launer is wrong in supposing that they are 'covered by funding of Regional Units'; Dr Tarsh is wrong in supposing that improving services peripherally will solve the problem (and also seems unaware of the cross-border flow into Salford!); and finally, Elaine Murphy is quite wrong with her silly and ill-informed sneer that our patients from outside are 'middle class people with minor ailments and a good prognosis' (*Bulletin*, June 1985, **9**, 121-22). I have worked in London teaching hospitals for much longer than she has, and can assure her that what may have been true of them once is certainly not true of us now. The point is worth stating, not only on our behalf but on behalf of Guy's, which is faced with dwindling resources every bit as much as we are: *tough cases are referred to teaching hospitals*.

A significant proportion of my clinical work load are people referred by their GPs for a further psychiatric opinion, as well as many cases referred directly by my consultant colleagues. There is nothing 'shameful' about such work: if Professor Murphy does not do it, there is something peculiar about her academic unit. However, I am sorry I made her blood boil, since that was presumably responsible for the meaningless