Exemption from prescription charges

DEAR SIRS

Vincenti writes (*Psychiatric Bulletin*, July 1992, **16**, 444) that sufferers of recurrent depression should be made exempt from prescription charges.

I argued that lithium carbonate be made exempt some years ago and was informed that as recurrent depressive patients did not have a deficiency disease or a recognised physical abnormality similar to diabetes, hypothyroidism or epilepsy, then a case could not be made for exemption. The real reason seems economic and is exemplified by the fact that I persuaded the DHSS to make food supplements prescribable for anorexia nervosa in 1982 as the numbers are small. But if one wishes to use food supplements to control calorie intake for overweight patients, or to supplement the poor diet of drug addicts, then the same supplements are not prescribable because the numbers would make it uneconomic.

I would suggest Professor Sims takes into account the political problems when he attempts to come to a decision at the Executive and Finance Committee of the College.

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(See Professor Sims' letter, *Psychiatric Bulletin*, November 1992, **16**, 724).

Psychiatry and the 'Old South Africa'

DEAR SIRS

The recent report on the parlous state of psychiatry in the 'New South Africa' (*Psychiatric Bulletin*, June 1992, **16**, 343–345) and an account of the horrors of working in Soweto's, Baragwanath Hospital by a surgical officer (Goodman, 1992) prompted my own recollections of psychiatric care in that same hospital in the 'Old South Africa'.

Baragwanath is perhaps the largest hospital in the southern hemisphere serving Soweto's teeming population of three million. While a medical officer in one of the three professorial units of medicine for nine months in 1985 just prior to the State of Emergency I saw every bed, and the mattress between each bed, filled with patients. Technical resources and medical staffing were also stretched, and had been so for years. The work for all staff was mentally and physically exhausting. Yet there was a profound belief in providing the best possible medicine. This determination coupled with both the adversity and the vast resources of clinical material produced considerable medical expertise. There was quality in all medical specialities but one – psychiatry.

All patients were sent through casualty to either duty medical or surgical teams. Psychiatric patients were 'medical' and like most others presented late in the course of their disease. Neurotic illnesses were rarely seen. Frankly psychotic men and women were brought down from casualty, often terrified and aggressive, and requiring considerable restraint or a straitjacket. If one happened to break free a gang of nurses abandoning their duties would give chase with squeals of laughter. These nurses received minimal psychiatric training.

In the chaotic atmosphere of the admission ward medical staff were extremely pressed for time. Although obviously patients needed to be calmed and given an explanation of what was happening, this often proved to be impossible. Doctors rarely spoke Zulu well enough if the patient spoke no English. Patients were restrained and given the most powerful anti-psychotic at hand.

Once transferred to the ward they were placed in a cot with leg and arm restraints. Despite the size of Baragwanath there was no psychiatric department. They would await referral to the psychiatrist who visited the hospital twice weekly, while they remained on the ward heavily sedated. Later they were transferred to a psychiatric hospital.

There was no justification for this travesty of psychiatric care based on the pressure of numbers of patients with life-threatening illnesses. Apartheid fosters and creates ill-health, both physical and mental. Baragwanath seemed for many to epitomise the war against medical apartheid, but alas, there was no psychiatric front. Existing resources were least available to psychiatry.

Despite the inconceivable changes that have taken place since 1985 such as the releasing of imprisoned ANC activists, little will have changed for the psychiatric patient and may not for some years. For them New South Africa will be a new label on old wine.

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Reference

GOODMAN, D. (1992) All in a day's work. *British Medical Journal*, **304**, 1061–1062.

Confused wandering

DEAR SIRS

Kathleen Dougan and Carrick McDonald (*Psychiatric Bulletin*, August 1992, **16**, 478) present further evidence that wandering does not increase around twilight as has been claimed to be the case. It is worth drawing attention to a much older study by