

remove her forcibly from the hospital. Fellow consultants, the Mental Health Act Commission, hospital managers and trust solicitors agreed that the patient's best interests were paramount, but were unable to give practical advice. We decided that she should not have leave at that time, and the wedding was postponed with her agreement.

Were we ethically and legally justified in preventing her marriage as her decision to marry (we assume) was made when she was well? Had she married, could her illness become the basis for later annulment?

Miss A's fiancé subsequently agreed for her to be detained under section 3 of MHA. She was treated with ECT, to which she responded, but remained a high suicide risk in the early stages of treatment. In spite of thoroughly and repeatedly explaining the severity of her illness to her fiancé, he was party to her repeated removal from hospital. Only the threat of legal action was sufficient to prevent this and to allow her to receive treatment. He was fully informed of his rights to apply for her discharge but did not pursue this. He appealed to hospital managers who upheld the section. She eventually recovered, was discharged and now attends the day hospital, where she is reported to be well.

To treat disturbed patients without the full co-operation of relatives is difficult, but to anticipate and manage surreptitious attempts to remove patients from hospital illegally poses special problems. What other steps might be taken to prevent the removal of the vulnerable from hospital? Have other readers found themselves in similar circumstances? We welcome comments on the legal issues raised and suggestions as to how best to resolve such problems.

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### **Supervision registers**

Sir: I am writing this letter about this matter after a thought-provoking talk given at the College's recent East Anglian meeting.

It was made apparent that the Department of Health would not budge from their decision to implement these registers. In some areas there are over 200 patients on the register already.

The Department of Health has given its overall guidelines and criteria for placing patients on these registers. It may be a good idea for the College to develop its own operational criteria so there are no ambiguities in the minds of psychiatrists or vague interpretations in coroner's and courts of law when tragedies occur. In this way the College would determine good practice and there would be no other use of these registers except clinical and patient care. Similarly, there should be withdrawal operational criteria which would benefit patients and doctors alike.

To help in this, a brief depression and suicide risk questionnaire may help. Like all operational criteria these would not be perfect but one can review and audit them regularly.

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### **Communication between GPs and psychiatrists (or communication between psychiatrists and GPs!)**

Sir: The article by Prakash Naik & Alan Lee (*Psychiatric Bulletin*, 1994, 18, 480-482) highlights not only, as they mention, "problems in communication between hospitals and GPs" but also the difficulties experienced by those in secondary care trying to influence the behaviour of their colleagues in primary care. Such difficulties also apply to GPs trying to influence behaviour of hospital staff.

Closer understanding of GPs' working patterns, roles and responsibilities by secondary care staff is required if progress is to be made towards resolving such 'problems in communication'. One step forward would be an increase in the number of psychiatric trainees doing attachments in general practice (Burns *et al*, 1994). Likewise, GP insight into the working of the psychiatric team is vital.

GPs receive a large amount of mail daily (the 'thud factor'). It is impractical for them to absorb and then implement all requests received. Perhaps, as the authors themselves hypothesise, a telephone or personal contact would have had more impact of referrers' behaviour than a ten page guide or letter? Prospectively it would be interesting if the authors met at least some of the GPs