Editorial Board of the *Journal* and, indeed, specifically eschew dogmatic utterances. Admittedly they clearly approve the Kantian imperative and their letter implies that they are probably rule deontologists. However, rule deontology has been and remains a perfectly respectable ethical position. I trust that what appears to be an over sensitive response to the views expressed by Scorer and Johnson does not reflect preference on the part of the *Journal*, positively or negatively, for any group of ethical theories.

References

[1]Nobel and Mason. *Journal of Medical Ethics* **4**: 68, 1978.
[2]Merskey. *Ibid.* pp. 74–77.
[3]Pietroni. *Ibid.* p. 94.

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Mental disease

SIR,

Whilst agreeing substantially with Dr. Flew's drift (Mental disease, *Journal of Medical Ethics*, 1978, **4**, 89–90) I find he has oversimplified his argument to the point of rendering it naive.

He suggests that mental disease must necessarily involve some sort of incapacity and/or discomfort in the persons thus afflicted. He maintains that this much is essential to the notion of disease. Subsequently he discusses the inadequacies of concepts of mental illness which he considers do not measure up to this essential; the central plank of his thesis is that physical diseases do.

Let us examine this plank. There are a number of physical diseases which do not involve discomfort or incapacity, e.g. benign pulmonary sarcoidosis, often detected on routine chest X-ray, essential hypertension in its early stages, and others. Are these not to be considered diseases? Moving into the realms of personal choice and will, does he consider that cigarette smoking (as a known precursor of organic damage) does not come within the province of the physician because it does not present as a complaining patient?

His argument that mental illness should not be considered as a type of deviant behaviour is attractive. However, in the most severely incapacitated paranoid schizophrenic, about whom little typological doubt exists, it is *other people* who decide that the person is incapacitated and then usually on the grounds of a description of the syndrome in behavioural terms. It is inhumane to consider that this condition be dealt with by any agency other than the medical profession yet the form of definition of disorder is qualitatively the same as, say, the definition of a football hooligan. It is not possible therefore to distinguish, using Dr. Flew's criteria, between mental illness and misfits or rebels.

This does not mean that this cannot and should not be done. It certainly seems inevitable that predominant societal attitudes will adjust the fine tuning of this process.

In America, and Dr Flew uses one American author heavily, the consumerism of medical practice encourages the medicalisation of many problems of living. Few American psychiatrists would turn away a patient, I suspect, however trivial his complaint, and indeed psychoanalytic theory (very prominent in American practice) justifies involvement in any persons life if that person wishes it. It is also true to say that the same theory or at least the majority of its practitioners would not consider it helpful to incarcerate and treat against their will such a person – indeed it cannot be done since the therapy depends upon a will determined commitment.

In this country consumer medicine is not predominant and the medical model, in a sophisticated form, is not disowned or despised by the majority of psychiatrists. It is recognised for what it is, a pragmatic *modus operandi* with major deficiencies, but one which has not yet been superseded.

Dr Flew should read British authors on the problems of definition and diagnosis in psychiatry for a full exposition of this point.[1] To return to societal attitudes, he rightly underlines the dangers of the definitional problem. He produces the Soviet Union as an example of a society which misuses the mental illness concept. This is of course correct but an inevitable consequence of the combination of two elements. One is the totalitarian régime which attempts to define desirable social behaviours and attitudes centrally, and then to impose those attitudes on the people, and the other is the actual continuum of disturbed behaviour in individuals along which the mental illness cut-off point is arbitrarily set.

In this country a variety of social forces inter-relate to set this cut-off point which will from time to time become solidified in a Mental Health Act this being an uncomfortable compromise.

It is not possible by Dr Flew's criteria to produce a workable humane system for distinguishing mentally ill persons. To conclude as he does that the patient's complaining alone should be the arbiter is to deny many suffering individuals their right to assistance and, in many cases, recovery.

References

[1]Kendall, R. E., (1975) *The Role of Diagnosis in Psychiatry*, Blackwell Scientific.

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