was able to pursue her hobbies, including creative writing and collecting antiques. At the time of her death she was in the process of writing her autobiography.

Helen was a warm, loving, strong, caring person; she embodied the qualities of struggle over personal difficulties while continuing to contribute a life of service to her community. Her rheumatoid arthritis led to renal failure but she maintained a determined independence and drove herself regularly to the local hospital for dialysis. Sadly the combination of renal failure and a further arthritic review led to her death in July 2001, aged 59.

She leaves a brother and myself, a sister, and much loved nieces and a nephew.

Sue Wilson

Arthur Manfred Shenkin

Formerly Consultant Psychiatrist
Southern General Hospital, Glasgow

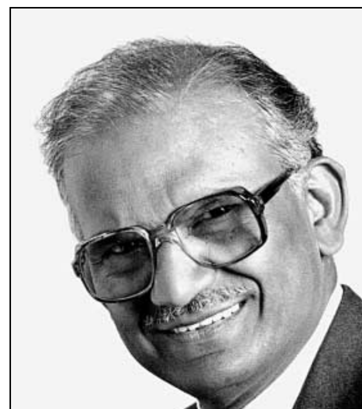
Arthur Shenkin, who died on 25 January 2002, was a pioneer in bringing psychiatry into general hospitals in post-war Glasgow, at a time of much hostility from other hospital doctors to psychiatrists and their patients. A tall man, with a commanding presence, his nature was warm and gentle. With his charm, and great reserves of patience and tolerance, he could calm the most disturbed patients and – much more difficult – awkward colleagues on medical committees.

Born on 1 March 1915 in Glasgow, the son of Latvian Jewish immigrants, he spoke in a medley of three languages in his pre-school years, and always regarded this as a formative influence. He was educated at Hutchesons' Grammar School and Glasgow University where he graduated MBChB in 1942 and elected FRCP (Glasgow) in 1971. In his student days his fierce commitment to socialism and Zionism, and his involvement in the politics of the 1930s, competed with his medical studies. When he qualified in 1942 he served in the Royal Air Force at home and in India, latterly in psychiatry. Demobilised in 1946, he joined the staff of the Southern General Hospital, where he found the psychiatric wards of the former Poor Law Hospital housing some 130 chronically ill patients. In a short time he reorganised the unit, created active treatment wards and opened the first out-patient clinic in the area. The unit thrived to such an extent that, after the NHS was created in 1948, it was chosen to house the new University Department by Glasgow's first Professor of Psychological Medicine, T. Ferguson Rodger. In his 28 years at the Southern, Arthur bore a heavy clinical load, played a full part in teaching and, in what for others would have been leisure time, developed a large private practice. He was interested in the psychological problems of the physically ill and developed services for them in the expanding general hospital. Twenty years later the rest of psychiatry caught up with him and named his activities 'liaison psychiatry'. In the 1950s he began to instruct ministers in pastoral psychology, another innovation, which developed over the years into a regular undergraduate course in the Faculty of Theology. He was rightly proud of his respected status there. Before he retired in 1976 he had helped to secure the Walton Conference Suite for the hospital and had chaired many of its committees. Retirement for him meant continuing work until the century ended. He became a tutor in psychotherapy at Dykebar Hospital, Paisley, continued his private practice and expanded his medico-legal work. He was in demand as an expert witness in the courts until his late 70s. He lectured extensively and was president of the Glasgow Royal Philosophical Society from 1996 to 1998. He was a man of wide interests and a great and combative talker, with a fund of stories and proverbs that he deployed effectively both in company and the consulting room. He was an authority on the prophet Hosea, and over many years wrote and rewrote an epic poem in Scots on the theme of the Creation, in which God featured as a woman. This amusing and original work was acclaimed by the many learned societies to which he delivered excerpts. He remained a socialist throughout his life, and never lost his loyalty to the cause of Israel. Through all these years he was sustained by, and devoted to, his wife Lillian, also a full-time doctor, and his three daughters. He took pride in his growing band of talented grandchildren, and lived to see one of them a consultant physician. In old age he recovered completely from a fractured neck of femur and major surgery on an aortic aneurysm. He died full of years, clear-minded to the end, after a life well-lived.

Malcolm Ingram

Duraiswami Gaspar

Formerly Consultant Psychiatrist
Little Branwick Centre, Small Heath, Birmingham



Dr Duraiswami Gaspar, known to his family, friends and colleagues as 'Sammy', died suddenly at his home in Birmingham on 10 December 2001. Born in Madras in 1934, he received his education in that city and graduated MBBS from Stanley Medical College in 1958 after a distinguished undergraduate career culminating in his being awarded a prize as 'best outgoing student'. In early years he trained as a general physician with an interest in cardiology, and was awarded the MD degree by his College in 1963.

However, in 1968 Sammy decided to leave India and seek his fortunes in the UK. In that year he began his new career as a psychiatrist with an appointment as registrar at Moorhaven Hospital, Ivybridge, subsequently moving on to West Park Hospital, Epsom, and thence to St George's Hospital, Stafford, where he began his higher training. During this period he showed his typical resolution in studying for and gaining both the MRCP (England) and the DPM (England) qualifications. He came to Birmingham on the regional training scheme for senior registrars in 1971, training in the psychiatric department at the Queen Elizabeth Hospital and the Midland Nerve Hospital, and was appointed consultant psychiatrist at Hollymoor Hospital, Birmingham, in 1974. Within 2 years he agreed to take over the consultant responsibility for the care of those patients in the hospital who were suffering from dementia and for all referrals of dementia. With a small and dedicated team, a service with a strong orientation towards care in the community was developed. Thenceforth, his involvement with the speciality of old age psychiatry, as it in due course became, flourished so that in the space of a few years it became a first-class service based in Hollymoor Hospital and East Birmingham (now Heartlands) Hospital.

He had a special fondness for teaching, to which he devoted much of his time and

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columns

energy. As a pioneer in his field in the West Midlands, he was instrumental in recruiting junior staff into old age psychiatry. He was the first to represent the West Midlands on the Faculty Executive in its early years, and during his tenure of office as chairman of the Regional Higher Training Sub-Committee, the West Midlands was one of the first regions in the country to set up a separate training scheme for old age psychiatry. His commitment during those years in office was instrumental in a strong foundation being laid for this scheme, and it is part of his legacy that his strength has endured. The major contribution he made to his speciality was recognised with his election to FRCPsych in 1985, and he was further rewarded with the granting of FRCP in 1995. He was a fine clinician and a caring, compassionate doctor. As a colleague he was strong in support, and a team player.

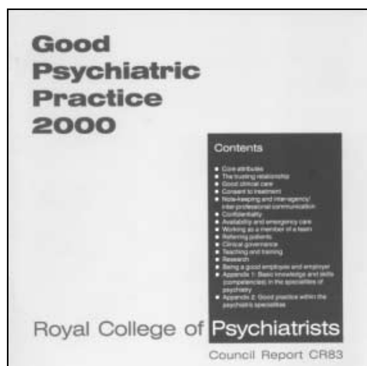
Following his retirement in 1999 he kept up his lifelong interest in politics and devoted his energies to creative writing, computer studies, travel and, above all, to the interests and wellbeing of his family. He was a loving and devoted husband, father and grandfather. His wife and their five children and two grandchildren survive him.

Tom Fenton
Elizabeth M. Gregg

reviews

Good Psychiatric Practice 2000. Council Report CR83

By Royal College of Psychiatrists. London: Royal College of Psychiatrists. 2000. 48 pp. £5.00. ISBN: 1-901242-57-9



This report is the College's contribution to a process that all Medical Royal Colleges are undertaking, the purpose being to set out standards of acceptable practice for the appraisal and revalidation of doctors. It sets out standards for psychiatrists, and juxtaposes these with relevant sections of the General Medical Council's (GMC) *Good Medical Practice*. The first edition of *Good Psychiatric Practice* welcomes comments for improvement, which is just as well because the document leaves plenty of scope for this.

The difference between medicine and psychiatry emerges starkly in the first section on the importance of trust in doctor–patient relationships (pp. 5–6). Among other things, the GMC document stresses the importance of respecting patients' rights to be fully involved in treatment decisions, and their right to decline treatment. The College report goes as far as acknowledging that there is a 'difficulty' in psychiatry, where those with mental illness may have a different view of their needs from their carers or, more significantly, their psychiatrists. The relationship between doctor and patient in psychiatry and medicine is not the same. Most patients would accept the view of a physician that their chest pain on exertion occurs because their coronary arteries are narrowed. Many psychiatric patients reject the notion that they hear voices because they have a condition that psychiatrists call schizophrenia. Everybody knows that if you decline treatment for angina, no one will force you to take it. This highlights a fundamental weakness of the College report; it fails to acknowledge or grapple with the complex ethical dilemmas that arise when patient and psychiatrist fail to agree on how to understand the nature of the patient's experiences. This failure demonstrates how important it is that we explore the issue of the contested nature of mental illness, both conceptually and ethically. If you like, it demonstrates the need for clinical practice to be combined with a critical philosophical analysis.

This becomes even more apparent when we consider the issue of consent to treatment (p. 15). Conflicting interpretations of mental illness imply conflicting notions of how we should act. Recent user-led research (Mental Health Foundation, 2000; Rose, 2001) has illuminated this complex area, demonstrating the need for a diversity of responses. While many service users find medication helpful, many are profoundly unhappy that psychiatry can be used to impose on them a biomedical interpretation of their experiences. This means that good psychiatric practice must involve a great deal more than 'awareness of the rights of the individual', or 'engaging patients . . . in full and open discussions about treatment options', and it is sad that the document makes no mention of the role of advocacy or advance directives here. Advocacy is extremely valuable in the difficult ethical negotiations around treatment, especially where coercion is involved (Thomas & Bracken, 1999). Psychiatrists' understanding of advocacy leaves much to be desired (Lacey & Thomas, 2001), so the report's failure to refer to advocacy is even more significant bearing in mind that the new Mental Health Act will attach particular importance to advocacy for detained patients. Likewise, advance directives can play an important part in extending competence when service users are temporarily not competent to make decisions about their care. Although the legal status of these documents has yet to be established, it would have been helpful if the report had made some reference to advance directives. At the very least there might have been encouragement to the profession to try and respect a patient's directive.

The expression 'good psychiatric practice' suggests that we should be concerned above all else with values. Sadly, this document really fails to grapple with the complexities that arise when different values and beliefs conflict in the area of mental health. Given the changing context of mental health care, one that accords greater prominence to users' voices, in the shadow of a Mental Health Act that represents a significant shift from care to coercion, this document will fail to move our practice with the times. But it is a start, and if, as the foreword indicates, there is a willingness to listen to comments, we may yet move on.

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This booklet is the first edition of what is hoped will be the key document setting out agreed standards for practice in psychiatry. The introduction welcomes

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