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have their autonomy respected (Kennedy & Grubb, 2000).

As Lord Donaldson Master of the Rolls (MR) stated in *Re R* (1992) '. . . consent by itself creates no obligation to treat'. Even if there is valid consent, if the child or parent is against this course of action this will have to be weighed in the balance. Whether, when and how to treat are matters of clinical judgement. The two cases *Re R* (1992) and *Re W* (1993) shed some light on the legal perception of consent. In the first of these cases, Lord Donaldson MR likened consent to a 'key' that unlocked the door to allow the doctor to treat; in the second he used the analogy of consent being a 'flak jacket' protecting the doctor from possible litigation or prosecution.

Conclusion

This small-scale survey suggests that there are basic misperceptions among child and adolescent mental health professionals regarding the legal nature of consent and how the law in this area applies to minors. It is necessary to have a sound knowledge of the law relating to consent in children in general, before considering the treatment of mental disorder without consent. In the quiz, how well did you perform?

Declaration of interest

None.

References

BRIDGE, C. (1997) Adolescents and mental disorder: who consents to treatment. *Medical Law International*, **3**, 51–74.

DEPARTMENT OF HEALTH AND THE WELSH OFFICE (1999) *Code of Practice: Mental Health Act 1983*. London: Stationery Office.

DEPARTMENT OF HEALTH AND THE WELSH OFFICE (2002) *Draft Mental Health Bill*. London: Stationery Office.

FENNELL, P. (1992) Informal compulsion: the psychiatric treatment of juveniles under common law. *Journal of Social Welfare and Family Law*, **4**, 311.

FENNELL, P. (1996) *Treatment Without Consent. Law, Psychiatry and the Treatment of Mentally Disordered People since 1845*. London: Routledge.

KENNEDY, I. & GRUBB, A. (2000) *Medical Law 3rd Edition*. London: Butterworths.

McCALL-SMITH, I. (1992) Consent to treatment in childhood. *Archives of Disease in Childhood*, **67**, 1247–1248.

PEARCE, J. (1994) Consent to treatment during childhood. The assessment of competence and the avoidance of conflict. *British Journal of Psychiatry*, **165**, 713–716.

Gillick V West Norfolk and Wisbech Area Health Authority (1985) 3 All ER 402, (1986) AC 112

Re J (a minor) (wardship: medical treatment) (1990) 6 BMLR 25

Re R (a minor) (wardship: medical treatment) (1992) Fam 11

Re W (a minor) (medical treatment) (1993) All ER 627, (1993) 1 FLR 1

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SWARAN P. SINGH

Caring for Sikh patients wearing a *kirpan* (traditional small sword): cultural sensitivity and safety issues

Devout Sikh men wear the *kirpan* (a traditional small sword) as part of their religious faith. The *kirpan* is one of five symbols of Sikhism (the five *K*s described below). Many traditional Sikhs undergo the *amrit* ceremony, akin to baptism, following which they are meant to wear the five *K*s at all times. Several legal controversies have emerged in the West, especially in the USA (Lal, 1999) and Canada (Wayland, 1997), over safety issues related to the *kirpan*, such as students wearing it to school or passengers wearing it during flights (for an overview of the recent cases, see www.sikhs.ca/kirpan).

Some educational institutions in the UK have been provided guidelines to ensure that Sikh students are allowed to wear the *kirpan* without compromising health and safety standards (http://www.dfes.gov.uk/schoolsecurity/dwtannexf.shtml). In-patient psychiatric services looking after Sikh patients may face similar dilemmas between respecting the Sikh religious traditions and ensuring safety of the patient and others. This paper briefly outlines the history of Sikhism, summarises the importance of the *kirpan* in the Sikh tradition and recommends policies that health authorities and mental health trusts can adopt to ensure that when caring for Sikh patients, neither cultural sensitivity nor individual safety are compromised.

Overview of Sikhism

This is a brief outline and interested readers can find more details in Singh (2001), McLeod (1989) or at several websites (www.sikhnet.com; www.allaboutsikhs.com; www.sikhs.org; www.srigurugranthsahib.org; www.sikhnation.com). There are 22 million Sikhs worldwide, 20 million of whom live in India. The religion emerged in the state of Punjab, North India, in the 16th century. The founder of the faith, Guru Nanak, was born in 1469 AD into a Hindu family during a turbulent period of serious conflict between the ruling *Mughals* (Muslim invaders from Persia) and the majority Hindu population,

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and also between upper and lower caste Hindus. Nanak preached the essential unity of mankind and argued against the caste system and polytheism. Combining the Hindu concept of *karma* (righteous deeds) with the Muslim concept of monotheism, Nanak rejected rituals, asceticism, monasticism and formalism in favour of egalitarianism (including complete equality of sexes), social order, communal harmony and charity. His followers became known as *Sikhs* (from the original Sanskrit *shishya*, or disciple/pupil, with Nanak as a *Guru*, or teacher). The basic tenets of Sikhism are that there is only one God (*Akaal Purakh*), who is timeless and formless and whose essence is power and love. Everything in the universe occurs within the will of God (*Hukam*). Humanity is the highest creation of God and human beings have been bestowed with free will. Humans should restrain the five passions of *kaam* (lust), *krodh* (anger), *lobh* (greed), *moh* (undue attachment to possessions or people) and *ahankar* (false pride), with the eight virtues of *gyaan* (wisdom), *sat* (truthful living), *niaon* (justice for all), *santokh* (temperance, self-restraint), *djhiraj* (patience, tolerance), *himmat* (courage), *namrata* (humility) and *sabar* (contentment, freedom from fear). The writings of Nanak and other Gurus are compiled in the Sikh holy book, *Guru Granth Sahib*, which for Sikhs, embodies the living spirit of the Gurus.

Sikhism spread under the leadership of the ten Gurus at a time of increasing Mughal oppression, especially under the rule of the Mughal emperor Aurangzeb, who levied higher taxes on non-Muslims, destroyed Hindu temples and suppressed popular revolts with large scale massacres. Guru Tegh Bahadur, the ninth Sikh Guru, asked Aurangzeb to stop the persecution of non-Muslims. In November 1675, Guru Tegh Bahadur was publicly beheaded at the orders of Aurangzeb at what is now a famous Sikh temple, *Sis Ganj* in Delhi. His son, the tenth Guru Gobind Singh, created an army of soldiers known as the *Khalsa* (from *Khalis*: pure) in a ceremony on 30 March 1699. *Khalsa* were an army of 'saint-soldiers', created in a ceremony of *amrit chhakna* (the ritual taking of nectar) and were required to wear five *Kakkars* (*kakkar* is the letter k in Punjabi). All Sikh men, who underwent the *amrit* ceremony, were thereafter to be called *Singh* (lion) and women as *Kaur* (Princess), repudiating and replacing the caste-based surnames. The five k's are *kes* (unshorn hair, as a sign of a saint), *kangha* (a small comb to keep the hair tidy), *kachhehara* (riding breeches, a symbol of continence), *kara* (literally a link, a steel bangle worn on the right wrist, as a reminder of the bond between a Sikh and the Guru, and for the need for restraint) and the *kirpan* (Fig. 1). *Kirpan* (from *kirpa*: mercy and *aan*: honour) symbolises power and freedom of spirit, and is a reminder to Sikhs to fight injustice and oppression, but is not to be used as an instrument of violence.

Fig. 1. The Sikh kirpan

Safety issues related to the *kirpan*

In the now famous 'Quebec *kirpan* case' (www.sikhs.ca/kirpan), the public perception of the *kirpan* was that it was a potentially dangerous 'weapon'. Sikhs do not perceive the *kirpan* as a weapon, and the translation into 'dagger' is inappropriate, given the pejorative association between a dagger and violence. However, no English term captures the true cultural meaning of the *kirpan*.

The *kirpan* is symbolic rather than functional, and is a reminder to Sikhs of their duty to fight injustice and maintain independence of spirit. It is usually about 8 inches long, is blunt and is worn sheathed and attached to a cloth belt, called the *gatra* (Fig 1). Such a *kirpan* is no more dangerous than a dinner knife and its use in an act of violence is practically unknown. However, there may be the rare instance of a patient wearing a potentially unsafe *kirpan*, such as one with sharp edges or a pointed tip. In even rarer instances, a patient may insist on wearing a much longer *kirpan*, such as the 3-foot long ones that are worn on ceremonial occasions. In such cases staff may have reasonable concerns about safety but feel unable to discuss the issues, lest cultural sensitivities are compromised. Even if the Sikh patient himself is not deemed at risk, a *kirpan* may be considered a 'health hazard' if another violent patient may somehow gain access to it.

Recommendations

A greater awareness of the cultural and religious meaning and significance of the *kirpan*, and knowledge of Sikhism in general, is a prerequisite for appropriate management of such issues within mental health. Areas such as Southall or Birmingham, which have large Sikh populations, are likely to have some staff from Sikh backgrounds, or with a greater awareness of Sikh religion and customs. However, while Sikhs have spread throughout the UK, knowledge about Sikhism is unlikely to be widespread, especially in areas with small ethnic minority populations. Mental health trusts should endeavour to produce leaflets on the religious and cultural aspects of different religious groups in both English and the minority language to facilitate understanding, improve cross-cultural communication and importantly, to allow the ethnic minority patients to feel that their belief systems are understood and respected. Specifically in relation to caring for Sikh patients wearing the *kirpan*, the following strategy might be useful.

1. Mental health trusts should develop leaflets in English and Punjabi, specifically addressing the issues related to the *kirpan*, emphasising both the staff's understanding of the importance of the *kirpan* to Sikhs and also concerns about potential risks. These should be available on all in-patient and day-care units.

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2. It is important to remember that not all Sikhs wear the *kirpan* and the issue will arise in only a small number of Sikh patients.
3. If a patient is wearing the *kirpan*, the staff should not automatically assume that it is dangerous. However, it may be necessary to examine the *kirpan* to ensure safety.
4. If there are concerns about safety, these should be discussed openly but sensitively with the patient and carers, explaining that the concerns are about safety and in no way challenging or judgmental of the religious traditions of Sikhs.
5. Patients and carers should be allowed to express their views including ventilation of any distress, since for devout Sikhs, the five *Ks* are the paramount and highly emotive articles of faith. Brusque, confrontational or insensitive handling of the discussion is only likely to appear insulting, and may polarise and entrench opinions.
6. Solutions should be allowed to emerge from within these discussions, rather than imposed. A simple solution might be to replace a potentially 'risky' *kirpan* with a smaller, safer one.
7. Mental health services may like to have a few sheathed *kirpans*, which meet health and safety standards, along with *gatras* (the cloth 'holster') on the wards. The patient should be allowed to choose one from these instead, and the family should be asked to keep the patient's *kirpan* at home during the in-patient stay. The ward *kirpan* and the personal *kirpan* can be swapped at discharge. *Kirpans* of various sizes and shapes can be bought at most Sikh temples and are often on sale in stalls outside the temple following the Sunday service.

Nothing defeats cross-cultural ignorance, anxieties and prejudices better than simple, straightforward and accurate information. Sometimes an excessive and inappropriate concern about cultural sensitivity masks a patronisingly dismissive attitude to the cultural needs of minority groups. Alternatively, genuine cultural sensitivity and concern about transgressing cultural boundaries may lead to important issues being ignored. For staff looking after patients from ethnic minority groups, this can be a delicate balancing act. It is hoped that at least in the area of Sikh patients wearing a *kirpan* and safety concerns, the above recommendations will help staff to look after patients in a clinically and culturally appropriate manner.

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References

LAL V. (1999) Sikh Kirpan in California schools: The social construction of symbols, the cultural politics of identity and the limits of multiculturalism. In *New Spiritual Homes: Religion and Asian Americans* (ed. D. K. Yoo), pp. 87–133. Honolulu, Hawaii: University of Hawaii Press.

McLEOD, W. H. (1989) *The Sikhs: History, Religion, and Society*. New York: Columbia University Press.

SINGH, K. (2001) *History of the Sikhs Vols 1 & 2*. New Delhi: Oxford University Press.

WAYLAND, S. V. (1997) Religious expressions in public schools: Kirpans in Canada, Hijab in France. *Ethnic and Racial Studies*, **20**, 545–561.

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Does crime literature contribute to the stigmatisation of those with mental health problems?

The Royal College of Psychiatrists is in the last year of its 'Changing Minds' campaign to reduce the stigma of having schizophrenia, substance use problems, dementia, eating disorders, anxiety and depression. As a mental health service user with a diagnosis of schizophrenia, I have been involved in the campaign since its outset and have become used to blaming the media, especially the tabloid press, for a large part of the stigma that people with mental health problems encounter. However, recently while in hospital I re-read an Agatha Christie book and began to wonder whether crime novels, with their usual starting point of a murder, could actually contribute as much to such stigmatisation. As Agatha Christie was probably the most prolific crime writer in the English language, this article examines some of her novels with a view to discovering the extent to which she played a part in the perception of the 'mad' killer.

Agatha Christie was born in 1890, the youngest of three children in a well-to-do middle-class family living in Torquay (Morgan, 1984). In total she wrote over 80 books with her first book, *The Mysterious Affair at Styles*, published in 1920 and her last, *Postern of Fate*, in 1973. Thus, she was born during the time of the rise of the large Victorian mental health institutions, and lived and wrote through the conception and the beginning of the implementation of community care. She herself had some kind of breakdown in 1926, when she disappeared for 10 days after losing her memory following the death of her mother and a request for a divorce from her first husband. She saw a psychiatrist briefly after this episode