the columns

New Ways of Working

Being told that New Ways of Working is a new way of working is not enlightening (tautologies are true but rarely helpful) but demonstrates the problem – it is whatever you decide it is.

Redefining the role of a psychiatrist is fine but Vize et al (Psychiatric Bulletin, February 2008, 32, 44–45) provide another tautology – ‘a role that encompasses the full scope of the work in which psychiatrists could be involved’. What people do is whatever is decided they do but this statement does not give a new ‘what’. New Ways of Working arose from a crisis in consultant recruitment, a mismatch between consultant expansion and training numbers (Goldberg, 2008); from perceived necessity, not choice, and as such it is a pragmatic business solution to a particular demand and resource problem, not better patient care. Changing roles is not new and was happening throughout medicine. Let’s be honest, not grandiose.

New Ways of Working is now used to legitimise redesign of any sort with services being destroyed for business reasons. Is it person centred or organisation centred? To improve the lives of psychiatrists or patients? Ironically, we will soon overproduce psychiatrists under Modernising Medical Careers while facing an impending crisis of nurse shortage.

Alternative ways of working are essential because solutions to the problems of one person, service, specialty or point in time may not be the solution for others. Vize et al must be clear not only what New Ways of Working is but also what it is not. Otherwise, it becomes whatever people, including primary care trusts and trust managers, decide it is. Everything is good because it is New Ways of Working. However, ‘new’ is not enough and ‘new’ is not necessarily good!


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New Ways of Working: fences and cuckoos

There is a clue in the capital letters: New Wales, Old ways = one way, Working= work avoidance. It is Newspeak.

It did not occur to me when responding to the histrionic outpourings of oppressed general psychiatrists (Jolley, 2002) that their despair would spawn a quasi-religious management sect. I drew attention to practices within other specialties which maintained morale and positive service profiles and suggested that a more equitable spread of manpower would reduce the difficulties.

In semi-retirement I have experience of general and old age psychiatry reconfigured to the model commended by Vize et al and Kennedy, and questioned by Lelliott (Vize et al, 2008; Kennedy, 2008; Lelliott, 2008). Every device is deployed to separate patients and families from consultants: to fragment patterns of care and to divert (‘signpost’) expectations and responsibilities elsewhere.

This is not the work of thoughtful, caring, clinical innovation which sparked and sustained my enthusiasm, confirming that we are available, with knowledge, skills and wisdom for people wherever they are in need (Jolley, 1976). Community psychiatry, including old age psychiatry, demonstrated professional humanity and superbly efficient use of resources. Let us return to the lessons of the recent past and set aside these ugly new clothes. Those who have been led astray are not to be blamed, but understood and thanked for the challenge they have given us. There is always something to be learned: we can do better. Taking down fences rather than sitting on them or jumping from them might be a good idea.


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New Ways of Working: power, responsibility and pounds

We need a debate on New Ways of Working (Psychiatric Bulletin, February 2008, 32, 47–48): good principles are being distorted by a range of conflicting influences — the most powerful is money (Sainsbury Centre for Mental Health, 2003). Doctors are expensive. Financial pressures encourage use of a cheaper member of staff whenever possible: replacing expensive staff with cheaper staff puts us at the cutting edge of New Ways of Working! This distorts team structure and working at all levels. Sometimes it might be appropriate, allowing highly trained staff to focus skills where needed. Alternatively it might deprive patients and families of access to expertise, and lead organisations to push staff to shoulder responsibilities which they feel are beyond their competencies or for which they are not adequately trained or remunerated.

Other pressures involve power and responsibility (General Medical Council, 2006). Undoubtedly there are people/organisations who see New Ways of Working as diminishing doctors’ ‘power’. Some fear that New Ways of Working diminishes medical responsibility, and leaves other staff carrying levels of responsibility that they are uncomfortable with, or worse, no-one has responsibility. But is power a finite package that gets cut up and doled out? Or can we become, by joining together, a more powerful force to work in the interests of patients and families?

Paradoxically, New Ways of Working stereotypes professionals. Organisations describe what different professionals do
and how they should be working and, instead of introducing flexibility, enforce rigidity. They lose person-centred holistic care by replacing skilled clinicians with tick-box policies and procedures (Drife, 2006) for people working beyond their competencies.


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Assessment of mental capacity: who can do it, or who should do it?

I was interested to read about the discrepancy in the number of capacity assessments carried out by doctors on general adult and old age psychiatry wards (Singhal et al, Psychiatric Bulletin, January 2008, 32, 17–19). Although the authors gave no explanation, the result could be because in-patients on the general adult wards, who probably lacked capacity, were more likely to be detained under the Mental Health Act and therefore fell outside the Bournewood gap.

This result does however support my belief that doctors on general adult psychiatry wards do not assess their patient’s capacity (to consent to treatment) often enough.

I took part in a survey (Hill et al, 2006) in which consultant and trainee psychiatrists were asked, ‘What are the key elements in the assessment of a patient’s capacity?’ Over a third of the 95 participants could only identify two or less of the five points in testing decision-making capacity (Department of Health, 2005, Re C, 1994). This suggested an inadequate level of knowledge and I believe that as doctors we could become even more de-skilled, should we rely entirely on our nursing colleagues to fulfil this role in future.

The authors make the point that, ‘Appropriately trained mental health nursing staff can undertake this assessment.’ I am sure they can, but should they?

I believe it is appropriate that as prescribing doctors, we should be assessing our patient’s capacity to consent to the proposed treatment, and not merely delegate these duties to other healthcare professionals. This makes sense from an ethical and medico-legal perspective.


Re C (Adult: Refusal of Medical Treatment)[1994] 1 AER 819.

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Re-examination of forensic psychiatry needs a proper examination of alternatives

Turner & Salters’ re-examination of the relationship between forensic and general psychiatry was provocative and rehearsed the criticisms from generalists towards their forensic colleagues (Psychiatric Bulletin, January 2008, 32, 2–6). No doubt it is important for forensic psychiatrists to consider external views in reflecting on their own practice. However, I feel it necessary to highlight the fallacy of simply adopting the US system, as was suggested by the authors. Their approach of effectively separating the treatment of offenders with mental disorders from the contribution of psychiatry to the courtroom brings with it serious ethical problems which should not be overlooked. One line of thinking, as advanced by Stone (1984), argues that clinicians should not act as expert witnesses as they cannot help but use their therapeutic skills at interview which may induce disclosures used by courts for non-medical purposes. However, this raises the unifying prospect of participants in the legal process unused to delivering psychiatric treatment being responsible for advising the court on mental health disposals. This does not seem to me in the interests of the justice or the best way to ensure treatment needs are met. An alternative view expressed by Appelbaum (1997) argues that psychiatric testimony falls outside traditional medical practice and therefore is not subject to traditional medical ethics, meaning that psychiatrists need not feel bound by medical ethics when acting as expert witnesses. However, it is difficult to see how a trained psychiatrist would not, unwittingly or otherwise, use their specialist interviewing skills in obtaining evidence from a defendant. For this reason they should be bound, at least in part, by the ethics of their profession.

In my view, the most appropriate approach to be taken in the UK was explained by O’Grady (2002), who incidentally provided the response to Turner & Salters’ article (2008). O’Grady argues that forensic psychiatrists should adhere to both justice ethics (truthfulness, respect for autonomy and dignity for the human rights of others) as well as medical ethics (beneficence and non-maleficence). This type of theory of ‘mixed duties’ was approved by the Royal College of Psychiatrists (2004). It encourages forensic psychiatrists to be highly sensitive to the ethical dilemmas inherent in their sub-specialty. I acknowledge the brief nature of Turner & Salters’ article, but feel their suggestion that the problems they perceive could be resolved simply by adopting the US practice is overly simplistic and should have been accompanied by a description of the limitations of this approach.


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Does hyoscine need to be ‘legally’ prescribed?

A recent visit to the Wickham Unit (a low-secure rehabilitation unit) at Blackberry Hill Hospital, Bristol, by the Mental Health Act Commission raised a controversial issue regarding the legal prescribing of medication for individuals who are detained under the Mental Health Act. There was a case of a patient who had consented to treatment and had a Form 3B completed in accordance with Section

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58 of the Mental Health Act 1983, among others for clozapine. He was experiencing hypersalivation as a side-effect so was prescribed hyoscine hydrobromide. It was not thought necessary to include this on the Form 38 as hyoscine is not a psychotropic drug. The Commission, however, stated that the hyoscine was not authorised, meaning the medication had been unlawfully administered, and the Avon and Wiltshire Mental Health Partnership NHS Trust had to advise the patient about his right to seek legal advice.

Hyoscine appears twice in the British National Formulary, in the chapter on the central nervous system under 'Drugs used in nausea and vertigo' and in the chapter on anaesthesia under 'Antimuscarinic drugs'. Hyoscine is not classified under 'Antimuscarinic drugs used in parkinsonism'. Antimuscarinic drugs used for anaesthesia is quite distinct from 'Antimuscarinic drugs used in parkinsonism'.

We do regard the latter as needing to be documented on the legal paperwork, such as precurdile, because of an accepted recognition of good practice. Is it now the case that for any side-effect caused by psychotropic medication that is being treated by drugs, these drugs need to be listed on Forms 38/39? If so, should our patient's senna and metformin be listed as well, as the constipation and diabetes he has is likely (but of course not necessarily) to be a result of the clozapine?


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New exam structure – too much too soon?

The last examinations in the 'old format' have now finished, making the editorial and commentaries on 'The long case is dead' very timely (Ashhurst, 2007; Benning & Broadhurst, 2007; Tyrer, 2007). In addition, psychiatric training is undergoing significant change, particularly following the difficulties associated with Medical Training Application System, and Modernising Medical Careers.

With the move towards competency-based curricula, it is important to reassess the way that trainees are assessed. Objective Structured Clinical Examinations (OSCEs) are increasingly used to assess medical students instead of the traditional long and short cases. Long cases have been used in examinations since the 1970s and while standardisation of OSCEs is easier, each station provides only a snapshot of a candidate's performance. Work-place-based assessments are a useful addition in the assessment of trainees' competences and will now be the main method of evaluating their ability to perform a full comprehensive clinical assessment. However, these are new tools for both trainees and supervisors and it will take time and further development before they become a reliable method of assessment.

Many trainees have prepared for one examination format only to be forced into a new system, while the transitional arrangements mean that some aspects of the curriculum will not be tested in those who have obtained Part 1 and are exempt from Paper 2. Neither of these situations is ideal. An overlap between the old and new examination formats may have allowed an easier transition to a new way of working for trainees and help avoid the significant anxiety experienced by those affected by the changes.


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Forensic psychiatry and general psychiatry: re-examining the relationship

I have heard the essence of the Turner & Salter article (Psychiatric Bulletin, January 2008, 32, 2–6) before but repetition does not produce enlightenment. At root, it is an attack on a branch of medicine that the authors do not seem to approve of. That is odd: I cannot think of any other branch of medicine which attracts this kind of negativity.

As John O'Grady has explained in his reply (Psychiatric Bulletin, January 2008, 32, 6–7), there are many reasons why forensic psychiatry has developed. Nevertheless, one omission from the debate so far, which is surprising in view of one of Turner's other strong interests, is history. It is easy to trace the development of forensic psychiatry from about 1814 as a response to a growing awareness of the social and psychiatric problems presented by many offenders with mental disorders. The growing specialty of psychiatry was expected to take on this important group of patients. From the earliest years of this period, until the present day, general psychiatrists have tried to resist this expectation. Personally, I think that is entirely reasonable, as such patients require special facilities and special skills. However, it is unreasonable to complain when others take up the challenge instead.

For many years there were very few who took an interest in this work and very few facilities for such patients. As pressure from general psychiatrists, prisons and mental hospitals (which gradually declined in number increased), so did the demand for special skills. With that, overcrowding in the first forensic psychiatry hospitals, the special hospitals, also increased.

The natural professional response to this was for psychiatrists, with the unusual special interest in offenders with mental disorders, to get together to discuss matters, especially clinical matters, of mutual interest. A forensic psychiatry subcommittee of the Royal Medico-Psychological Association (the forerunner to the Royal College of Psychiatrists) was formed in 1963. This became a section of forensic psychiatry when the Royal College of Psychiatrists began in 1971 and, eventually, in 1997, the Faculty of Forensic Psychiatry. The clinical meetings of this developing organisation have attracted an increasing number of College members. Any psychiatrist is welcome to attend the meetings and general psychiatrists, as Turner and Salter know well, are especially welcome. We even invite them to express their negative views in debate! Perhaps there is a hidden agenda to all this. Speculation is usually unhelpful, so I will not indulge. Maybe I can, however, entice Trevor Turner to spell out more closely what ails him. Does he have the same allergy to other specialties, and if not, then why not? I think I can speak for the majority of members of the Forensic Psychiatry faculty when I say that they are always interested to learn new ways of working and to serve patients' interests better.

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Trainees' views on service user and carer involvement in training: a perspective from the West Midlands

A survey similar to Babu et al (Psychiatric Bulletin, January 2008, 32, 28–31) was
conducted in the West Midlands a year after it became mandatory to involve users and carers in psychiatric training. Completed questionnaires were received from 180 trainees and included specialist registrars from all specialties and senior house officers from all four rotations. A greater percentage of trainees (64% v. 47% in Babu et al’s survey) were aware of the College requirement for user and carer involvement in training. As with Babu et al’s survey, the most common setting was during case presentations (77%).

As many as 61% of senior house officers had experienced user and carer involvement in their Member of the Royal College of Psychiatrists’ academic programme compared with only 23% of specialist registrars.

The majority wanted users and carers to share their experiences and perspectives (82%) and to give feedback about their ability, attitudes and skills (70%). This was less so for involvement in planning teaching programmes (22%) and in selection of trainees onto training schemes (17%). This may be a reflection of the same reservations highlighted in Babu et al’s survey. Livingston & Cooper’s (2004) recommendation for training and support to users and carers would be essential in addressing these concerns. The introduction and implementation of this major component in training requires balancing the sensitivities and needs of both service users and trainees. Drawing from the experiences of other training schemes and the results of further research and audit will be an integral part in furthering this area of training.


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**Whose line is it anyway?**

There is an assumption (by psychiatrists) that all physical care is the territory of the general practitioner (Tarrant, 2006), whereas psychiatrists tend to focus on arranging appropriate monitoring of medications that they are prescribing. However, there is a growing awareness of the global physical health needs of those with severe and enduring mental illnesses. This is confounded by the current lack of a clear consensus from multiple and differing guidelines on the necessary monitoring for both primary and secondary care.

Patients with severe mental illness, such as schizophrenia, bipolar disorder and depression, are said to lose 25 years or more of life expectancy (Newcomer & Hennekens, 2007); the majority due to cardiovascular disease (CVD). It is not surprising then that psychiatric patients tend to have a higher prevalence of independent predictors of CVD including smoking, hypertension, obesity, a sedentary lifestyle and hyperlipidaemia—an ‘inherent’ predisposition to CVD.

However, there seems to be some disparity in prevention efforts for cardiovascular mortality when comparing individuals with severe mental illness and the general population. In a correspondence letter to the Bulletin, Dr Mohd (rightly) expresses his concern that action needs to be taken when any results or measurements are found to be abnormal. Results are often duly communicated to general practitioners by letter but may easily be overlooked. He goes on to suggest that we (psychiatrists) should initiate anti-lipid treatment ourselves (Mohd, 2006).

Yet, according to the most recent joint British Societies’ guidelines, the indications to commence antilipid therapy are quite clear: ‘at high risk’ – athero-sclerotic disease, diabetes or a high total CVD risk > 20% (British Cardiac Society et al, 2005). However, in patients with severe mental illness, the total CVD risk is often below 20% for that specific period of time.

Most research has focused on the impact of some antipsychotic medication being linked to quite marked hypercholesterolaemia (Correll et al, 2007). The reasonable deduction is that these patients can be offered an alternative, less lipid-inducing antipsychotic and/or lifestyle changes. Lifestyle advice is often difficult to implement on the background of ongoing and enduring psychiatric illness given that use of healthcare services often decreases after the onset of a psychiatric disorder.

Some may argue that cardiovascular risk in patients who are stable on regular antipsychotic medication should be treated the same as anybody else with the same risk factors. However, given that patients with severe and enduring mental illness (with/without antipsychotic medication) are ‘inherently’ predisposed to CVD, would it be sensible just to wait until the risk passes the 20% threshold? Or is there a ‘missed opportunity’ here.

Closer attention is needed, first, to the choice of psychotropic drug treatment and second, more aggressive in-hospital use of monitoring and interventions to identify and reduce risk. In this target-driven culture, we often assign arbitrary values to continuous and often fluctuating biological variables. Perhaps we ought to abandon the notion of ‘one threshold fits all’, instead, use our clinical judgment to initiate treatment based on overall risk.


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