columns

best represented by Anthony Clare's book *Psychiatry in Dissent*, which Holloway quotes.[4] Clare eschewed a well-defined basis for practice. In the recent issue of the *British Journal of Psychiatry*, Nassir Ghaemi argues for the need to move beyond such eclecticism.[5] Critical psychiatry is a potential way forward.

1 Holloway F. Common sense, nonsense and the new culture wars within psychiatry. Invited commentary on . . . Beyond consultation. *Psychiatr Bull* 2009; **33**: 243–4.

2 Double DB (ed). *Critical Psychiatry: The Limits of Madness*. Palgrave Macmillan, 2006.

3 Double DB. Historical perspectives on anti-psychiatry. In *Critical Psychiatry: The Limits of Madness*: 19–39. Palgrave Macmillan, 2006.

4 Clare A. *Psychiatry in Dissent*. Tavistock Publications, 1977.

5 Ghaemi SN. The rise and fall of the biopsychosocial model. *Br J Psychiatry* 2009; **195**: 3–4.

Declaration of interest

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New Ways of Working: are we prepared?

We completed an audit on New Ways of Working to compare the 60 most recent histories taken by junior doctors (STR1–3, including general practice trainees) and nursing staff in an out-patient clinic. The audit was done in Lymebrook Centre, which is one of the resource centres that caters for adult psychiatric patients in North Staffordshire Combined Healthcare NHS Trust.

All histories were assessed for 108 variables. In addition to assessing whether the relevant variable was reported, we also graded the information reported on whether it was comprehensive or only partially obtained. The data were collected on hard copy and analysed on SPSS version 13 for Windows.

This audit showed significant differences in histories taken by junior doctors and nurses. Doctors documented comprehensive histories for 52% of variables; they took incomplete histories for 8% of variables and did not ask for 39% of variables. Nurses have taken comprehensive histories for 32% of variables; they have taken incomplete histories for 13% and did not ask about histories for 55% of variables. There were statistically significant differences ($P < 0.05$) between the two groups in 44 out of the 108 variables, with doctors generally taking a more comprehensive and detailed assessment. The audit was presented within the Trust; nurses' representatives were asked for their views. They stated that history-taking, physical examination and pharmacology are not part of their nursing training, therefore they are not confident in these aspects of patient care (e.g. physical, pharmacological). They have identified difficulties in differentiating physical symptoms because of functional and biological causes. Torn & McNichol[1] found that 96% of nurse practitioners did not feel that their training adequately equips them to treat people with mental health problems and 83% did not feel adequately equipped to assess people with mental health problems. No other independent studies have since been completed and there is no other evidence available which would support New Ways of Working.

It is certain that psychiatry needs to change to provide better patient care and to overcome difficulties posed to the psychiatrists, but are we ready for it?

1 Torn A, McNichol E . Can mental health nurse be a nurse practitioner? *Nurs Stand* 1996; **11**: 39–44.

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The trouble with . . .

In two related articles – 'The trouble with NHS psychiatry in England'[1] and 'New Ways not Working? Psychiatrists' attitudes'[2] – misgivings about the role of the psychiatrist and service delivery in England are described. As psychiatrists working in Scotland, we have witnessed a divergence between the two National Health Services since devolution. The National Service Framework for mental health,[3] for example, was not implemented in Scotland. Further, bed closures have happened more slowly and the rushed 'top-down' functionalisation of mental healthcare enacted in England has been generally more measured north of the border. Indeed, it appears that only crisis resolution and home treatment teams have been widely adopted (reflecting in part the supporting evidence, for example Joy *et al*[4]), there being a more conservative adaptation of New Ways of Working.

Partially, this reflects a different politico-cultural backdrop in Scotland. There is, for example, a substantially smaller private and independent sector in mental healthcare here compared with England; funding, therefore, is not (usually) diverted in that direction. Furthermore, there is less preoccupation with risk to others, again limiting private secure facility expansion.

Additionally, New Ways of Working was in part a pragmatic solution to endemic problems with recruitment and retention into psychiatry. In Scotland, this has been less of an issue overall, with notable exceptions. Scottish workforce planning indicates that only child and adolescent mental health consultants are difficult to recruit in Scotland, and there has been a genuine uplift in consultant numbers in the past 5 years. Although there are important imminent universal challenges which could change the landscape (such as the diminishing number of junior doctors, and the evolving role of the psychiatrist as a medical doctor providing leadership within the multidisciplinary team), we contend that there is probably less dissatisfaction with current service configurations, less urgency to overhaul systems, and more opportunity to plan service change meaningfully on the basis of evidence and others' experience.

Thus, we have naturalistic experiment with separate and diverging systems of government-based healthcare in adjoining countries with similar underlying populations. This could be an ideal opportunity to examine optimal service configuration, as long as consensus on the best outcomes for patients could be achieved.

1 St John-Smith P, McQueen D, Michael A, Ikkos G, Denman C, Maier M, et al. The trouble with NHS psychiatry in England. *Psychiatr Bull* 2009; **33**: 219–25.

2 Dale J, Milner G. New Ways not working? Psychiatrists' attitudes. *Psychiatr Bull* 2009; **33**: 204–7.

3 Department of Health. *National Service Framework for Mental Health: Modern Standards and Service Models*. Department of Health, 1999.

4 Joy CB, Adams CE, Rice K. Crisis intervention for people with severe mental illnesses. *Cochrane Database of Systematic Review* 2006; **4**: CD001087.

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Journal club syndrome: a newly described disorder of doctors in training

Journal clubs and case presentation meetings are an important part of 'in-house' training and an opportunity for all doctors to practise and develop presentation skills. There are ample

columns

suggestions for improving the quality of such clubs, but I could not find any that identified risks associated with this practice. I am happy to provide what in my knowledge is the first case-series report, based on anecdotal impressions, of such risks, with the knowledge and responsibility that it may generate a new field of research and debate or the definition of a journal club syndrome.

My experience suggests that the period preceding a journal club is directly associated with an increase of physical and mental health problems on presenting doctors, to an extent that makes it impossible to prepare for or deliver the presentation. Mental health problems include temporary cognitive deficits (mainly in the form of episodic memory loss that recovers with no intervention), manifested by a high number of doctors that have forgotten either that it was their day to present or to bring on the day the wrongly called memory sticks that carried all the data. In the latter case, further symptoms include the lack of alternative supporting methods and the common perception that stand-alone oral presentation cannot be delivered. Accidents, thefts and losses are also reported on a higher proportion in the pre-presentation period, to the point that health and safety regulation of journal clubs may become standard practice one day soon.

This evidence has been accumulated through many years of training and working in different areas, which suggests that the risk is not associated to specific grades of doctors, disciplines, environments, hospitals, trusts or geographical areas. As I continue to be surprised by the high quality of some presentations, mainly of very junior doctors, and challenged by their enthusiasm, I hope that this newly described syndrome does not present with associated apathy to others involved in the journal club.

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The trouble with NHS psychiatrists

St John-Smith *et al*[1] provide a useful overview of the political imperatives which have shaped British psychiatry in the past 5 years, but as with other overviews[2] it is difficult for the reader to come away with any constructive message.

The authors rightly recognise the original New Ways of Working project as a practical response to a shortage of psychiatrists, but believe this has become a shorthand for cutting the number of medical staff and reducing the psychiatric orientation of the service. The national workforce figures suggest otherwise: between 1999 and 2007, the number of psychiatrists in England rose[3] by 46% and few can argue that recruitment is not vastly improved compared with 10 years ago.

The reality is that new services have grown even faster, with an estimated £2 billion of additional investment since 1999,[3] mainly in specialist teams. The recruitment of medical staff and the establishment of suitable training placements have lagged behind, as outlined by the Audit Commission finding that almost a third of crisis resolution teams had no dedicated consultant sessions.[4]

It is inevitable, and many would argue desirable, that non-medical staff will be involved in front-line assessment, as they are now in most other branches of medicine. The solution is not to decry 'proforma tools and guidelines', but to argue for these to be used by suitably trained and supervised staff working in teams with ready access to psychiatrists, as originally envisaged in New Ways of Working.[5] The College should lead on an overview of the medical staffing of specialist teams, and trusts and commissioners should be obliged to fund dedicated consultant sessions in order to meet their quality targets.

Although specialist teams provide some benefits, they have undoubtedly led to greater fragmentation of care and may not all survive beyond New Horizons.[3] Our battle should be to ensure that the additional money which came with these teams is not clawed back in times of greater austerity.

1 St John-Smith P, McQueen D, Michael A, Ikkos G, Denman C, Maier M, et al. The trouble with NHS psychiatry in England. *Psychiatr Bull* 2009; **33**: 219–25.

2 Craddock N, Antebi D, Attenburrow MJ, Bailey A, Carson A, Cowen P, et al. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.

3 Department of Health. *New Horizons: Towards a Shared Vision for Mental Health*. Department of Health, 2009.

4 National Audit Office. *Helping People through Mental Health Crisis: The Role of Crisis Resolution and Home Treatment Services*, 2007.

5 CSIP/NIMHE, CWP, Royal College of Psychiatrists. *New Ways of Working for Psychiatrists*. Department of Health, 2005.

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