the columns

correspondence

The limits of responsibility

Sir: I would like to take the opportunity to reply to my correspondents on the subject of responsibility (Bristow, *Psychiatric Bulletin*, November 2001, **25**, 412–413).

While Mr Howlett (*Psychiatric Bulletin*, November 2001, **25**, 414–415) is right to say that there may be duties imposed on physicians and surgeons regarding follow-up of their patients, none of these duties concern the patients' behaviour. If a person is arrested for homicide the fact that he/she has recently consulted an orthopaedic or gastrointestinal specialist will not even be remarked upon. But let it be known that he/she has seen a psychiatrist and it will be automatically assumed that the patient is incapacitated and the psychiatrist is culpable by omission for the homicide. An expensive 'independent' inquiry will then follow that, even if all parties are exonerated, will undoubtedly convey the impression that there is no smoke without fire, to the detriment of all concerned.

Mr Howlett also avers that responsibility should last as long as the patient is still considered a patient and has a responsible medical officer. We have to ask whose decision it is whether a patient remains a patient. Is a patient a patient just because he or she wants to be, or because current health policy says he or she should be so? Or does there have to be a reliable treatment for his/her disorder that can be administered whatever the degree of concordance. I think that to establish any sort of negligence the latter must be a condition. There are no such treatments for either personality disorder or substance misuse.

A recent case (R. *v* Crowley) attracted a fair degree of comment from, among others, Mr Howlett. In this case, where a mentally disordered offender was arrested after stalking and threatening a minor, it was reported that a crucial decision was taken in court to offer him bail against the advice of a forensic psychiatrist who considered him dangerous (Vasagar & Hopkins, 2001). He thereupon killed the individual he had stalked. If a psychiatrist had taken this decision he would have been subject to a media witch trial. But because it was a judge that took the decision we have seen no such comments.

What increasingly separates us now from physicians and surgeons, apart from the self-imposed exile so accurately described by Wessely (1996), is the lack of definition of our job, especially true in general adult psychiatry. First we had the 'severely mentally ill', then the challenge posed by 'dangerous severe personality disorder'. In my trust, and possibly in others there has been an attempt to foist child protection work on community mental health team members. If that wasn't enough we have the vague blandishments of the National Service Framework and the National Plan, which entitle virtually anyone at any time to any service they think they need.

Sorting out this issue of definition is crucial if we are going to attract any new entrants to the profession, not to mention keep the ones we've got.

VASAGAR, J. & HOPKINS, N. (2001) Mentally ill stalker gets life for killing boy. *Guardian*, February, 13.

WESSELY, S. (1996) The rise of counselling and the return of alienism. *BMJ*, **313**, 158–160.

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List of atypical drugs?

Sir: I realise that classifying antipsychotic drugs into typical and atypical is simplistic – but, understandably, everybody does it. Few, however, define it. In a previous issue of the *Bulletin*, Paton *et al* do by stipulating the drugs thought to be atypical for their work but they do not explain why these and not others were considered (Paton *et al*, *Psychiatric Bulletin*, May 2002, **26**, 172–174). As far as I understood, 'atypicality' was something to do with catalepsy in rats (Kerwin, 1994) or speed of dissociation from the dopamine d2 receptor (Kapur & Seeman, 2001), or both. In the same issue of the *Bulletin*, Taylor *et al* neither define atypicality, nor list the drugs under consideration (Taylor *et al*, pp. 170–172). To further confuse matters, they describe a study supplementing clozapine with sulpiride as evaluating the effects of the combination of atypical and typical drugs. Turning to the Maudsley Guidelines (Taylor *et al* 2001) for help I found none. Atypical antipsychotics are recommended for use for everyone with psychosis, yet a defined list is not provided. Using terms like new and old generation drugs is no better. It seems to be avoiding the key issue, which is the neuropharmacology/neuro-physiology, not the age or cost of the compound.

This is a genuine plea to authors; if the classification of typical–atypical is being used, please list what is being considered as atypical, and why are some drugs being considered and not others.

KAPUR, S. & SEEMAN, P. (2001) Does fast dissociation from the dopamine d(2) receptor explain the action of atypical antipsychotics? A new hypothesis. *American Journal of Psychiatry*, **158**, 360–369.

KERWIN, R.W. (1994) The new atypical antipsychotics. A lack of extrapryamidal side-effects and new routes in schizophrenia research. *British Journal of Psychiatry*, **164**, 141–148.

TAYLOR, D., MCCONNELL, D., MCCONNELL, H., *et al* (2001) *The South London Maudsley NHS Trust 2001 Prescribing Guidelines*. London: Martin Dunitz.

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Training late

Sir: Leaman and Lyle (*Psychiatric Bulletin*, June 2002, **26**, 233–234) suggest extending the concept of flexible training to include recognition of well-supervised experience in non-career grades for examination eligibility. I returned to psychiatric training in the late 1980s, early 1990s. The College allowed me to take the MRCPsych Part 1 examination when I was working as a clinical assistant, taking into account 8-months' senior house officer (SHO) experience I had gained 6 years earlier. Encouraged by passing Part 1 at my first attempt I returned to SHO training on what was then called the Doctors with Domestic Commitments Scheme. Some years later, when I came to apply for a consultant post, I know my experience as a clinical assistant was taken into account by the appropriate committee.

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columns

Although training part-time has, I believe, in many ways become easier in the past 10 years, it seems that the College should be more flexible in recognising the experience gained in well-supervised, non-career grade posts. With a large number of consultant psychiatry posts vacant in this country, we must do all we can to encourage experienced doctors back from 'the branch to the mainline' of psychiatry, while still maintaining examination eligibility standards.

Sara Walker Consultant Child and Adolescent Psychiatrist, Mount Gould Hospital, Plymouth

Primary care screening clinic

Sir: The primary care psychiatric screening clinic described by Hamilton *et al* (*Psychiatric Bulletin*, June 2002, **26**, 218–221) is an excellent idea. Joint interviewing is an invaluable tool in psychiatric practice.

However, in 1980 I took over from a consultant who had looked after a catchment population of 100 000 with one community psychiatric nurse, one social worker and no junior medical staff. He saw 80 out-patients each week: 10 minutes for new referrals and 5 minutes for returns. Medical records consisted of the date and a single abbreviation for the diagnosis. Clinic letters were three sentences or fewer.

My predecessor's diagnoses were usually proved right. General practitioners missed his rapid response to referrals and his brevity. Screening has its value but in the new world of primary care trusts it will be important that psychiatrists speak out for a full range of services for the mentally ill.

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the college

Distinction awards

College nomination procedures in England and Wales

The Department of Health is again undertaking a review of the procedures, operation and practice of the distinction and meritorious service award scheme. The following paper describes the College's current nomination procedure in England and Wales. The College's procedures will change for 2003/2004 and further details will appear in the *Bulletin* and on the College's website (http://www.rcpsych.ac.uk).

The President has identified two distinction award advisers in each NHS Region in England (apart from London, which has four advisers) and two in Wales. At least one, and often both, of the advisers will also serve on their regional awards committee. Statistics showing the speciality/gender/ethnic backgrounds of those consultants eligible for awards are produced each year by the College secretariat. Although awards continue to be made on merit, Regions, Faculties and Sections are asked to consider these statistics when submitting their list of recommendations.

Towards the end of the year the distinction award advisers in England and Wales, in consultation with the chairmen of Divisions and other senior award holders, produce a list of nominations in rank order for their region. The chairmen of Faculties and Sections (if eligible), in consultation with senior award-holders in their Faculty or Section, also produce lists in rank order. Senior College officers meet to consider members who have made a significant contribution to the College. They will also consider individual nominations from College members concerned that they have been overlooked.

These various lists of nominations are sent to the College and are merged to form one composite list. This is then sent to all committee members, together with the curriculum vitae (CV) questionnaires (but not the citations) shortly before the College's annual Distinction Awards Meeting, usually held at the end of January.

The President chairs the meeting and its members consist of the honorary officers, two distinction award advisers in each NHS Region in England and Wales, the chairmen of Divisions, Faculties and Sections (if they have awards). Its task is to produce the College's final list of nominations from the composite lists produced by the Regions, Faculties, Sections and honorary officers. The Chief Executive and her personal assistant provide administrative support.

Only the names on the composite list of nominations are considered at the meeting and then only if the CV questionnaires and citations have been received in advance of the meeting. The committee member who has made the nomination will speak briefly on behalf of each candidate. Some names are removed from the list at this stage. The committee are given ample time to consider the paperwork, together with the relevant statistics, and finally to cast their votes.

The final list of College nominations is then submitted to the Advisory Committee on Distinction Awards (ACDA). Further information of the distinction award procedures can be viewed at http://www.doh.gov.uk/nhsexec/acda.htm.

Any College Member who considers that he or she has been overlooked should write to the Chief Executive by 31 October, enclosing a completed 2003 ACDA CV Questionnaire form (these can be downloaded from the ACDA website at the above address). College Members must also give the name of a senior colleague willing to write a citation on their behalf. Any forms received will be considered by the officers at their meeting in December.

Vanessa Cameron Chief Executive, Royal College of Psychiatrists

The Role of Consultants with Responsibility for Substance Misuse. Position Statement by the Faculty of Substance Misuse

Council Report CR97
£5.00. 20 pp.

This position statement from the Faculty of Substance Misuse aims to identify and clarify the role and contributions of consultants with responsibility for substance misuse (addiction psychiatrists).

The statement recognises that consultant psychiatrists with responsibilities for substance misusers are one part of a multi-disciplinary team in which key disciplines and professionals have specific roles and contributions, and that there are particular groups of medical and non-medical professionals (e.g. primary care teams, criminal justice agencies) with whom consultants have mutually beneficial relationships.

Specific aims are:

(1) To provide consultant psychiatrists with a comprehensive outline of:
   (i) the potential roles of those with responsibilities for substance misusers;
   (ii) the variety of professionals and disciplines with whom consultant addiction psychiatrists work, liaise, collaborate and coordinate services;
   (iii) the range of interventions provided by consultant addiction psychiatrists and the spectrum of settings in which they operate.

(2) To provide a structure for the:
   (i) definition of components for consultant posts (e.g. for regional advisers to review job descriptions);
   (ii) description of the contribution of addiction psychiatrists for trainees;
   (iii) accreditation of training posts.

(3) To provide non-psychiatrists with an outline of the role of consultants in the

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