

### Prescriptions, licences and evidence

Sir: Healy & Nutt state (*Psychiatric Bulletin* November, 22, 680–684) that “the defence unions would not support the prescriber prescribing off-licence in the event that things went wrong”. On behalf of both the Medical Protection Society and the Medical Defence Union, I write to correct this misleading statement.

Members of our respective organisations are entitled to apply for advice and assistance in relation to any legal problem arising from their medical practice. So long as the prescription of a drug ‘off-licence’ is a part of normal clinical practice, we would of course respond to a member’s request for assistance.

As a separate issue, if litigation were to ensue following an adverse event then, as in all medical negligence cases, the defensibility of the doctors’ management is dependent upon obtaining expert support from other doctors practising in that (sub-)speciality. Broadly speaking, provided there is supportive expert opinion, then the claim will be defensible, irrespective of the wording of the drug licence.

We trust this clarifies the position for the readership of your journal.

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### Prescribing antipsychotics in child psychiatry

Sir: Slaveska *et al* (*Psychiatric Bulletin*, November 1998, 22, 685–687) have highlighted an important problem for child psychiatrists. Over two years only 64% of respondents had had contact with a child with psychosis. The number of cases seen was between one and 12 (median one case per consultant). One has to ask if these child psychiatrists can retain competence as prescribers of antipsychotics. Although the prevalence of psychosis is low in child psychiatry, the next child referred may be psychotic and in urgent need of medication. Child psychiatrists cannot therefore absolve themselves from responsibility for keeping up-to-date with new antipsychotics and prescribing them when appropriate. Another complication arises with the prescribing of clozapine in paediatric populations. In the study by Kumra *et al* (1996), toxic effects including neutropenia and seizures were more common than in adult populations. One approach to keeping child psychiatrists up-to-date with drug treatment might be to set up

groups where the ongoing management of psychotic child referrals was discussed.

### Reference

KUMRA S., FRAZIER, J. A., JACOBSEN, L. K., *et al* (1996) Childhood-onset schizophrenia. A double-blind clozapine-haloperidol comparison. *Archives of General Psychiatry*, 53, 1090–1097.

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### Use of antipsychotics by child and adolescent psychiatrists

Sir: Having recently completed a survey of 46 child and adolescent psychiatrists in the Wessex region (37 consultants and nine senior registrars) on the use of antipsychotics in first-episode psychoses, we found Slaveska *et al*’s (1998) paper particularly apposite. Our findings, however, contrast sharply. We developed a questionnaire, asking about the drugs psychiatrists would use to treat first episodes of psychotic illnesses. Forty-one out of 46 (89%) questionnaires were returned. Four respondents reported they never prescribed antipsychotics and did not complete the questionnaire, while one returned a blank questionnaire. The respondents had a mean of 9.8 years of experience in child and adolescent psychiatry. Fifty per cent would use risperidone, olanzapine or “a new antipsychotic” as their first choice, 24% would not prescribe new atypical antipsychotic as their first or second choice, while 12% would only use conventional antipsychotics as defined by Thomas & Lewis (1998). The doses used ranged between 200 and 800 mg chlorpromazine equivalents. Clinicians reported that differing side-effect profile, observing trends in psychiatric practice, training with clinicians with an established prescribing practice and adverse personal experience guided them most in their prescribing. Therefore, we found that the majority of the Wessex child and adolescent psychiatrists would prescribe atypical antipsychotics, as first choice, a finding that is very different from that found by Slaveska *et al* (1998). The wide variations in findings, however, highlights the need for further discussions on good medical treatment in this particular age group, especially as their first experience with psychopharmacological treatment may well significantly influence their future compliance.

## References

- SLAVESKA, K., HOLLIS, C. & BRAMBLE, D. (1998) Use of antipsychotics by child and adolescent psychiatrists. *Psychiatric Bulletin*, **22**, 685–687.
- THOMAS, C. S. & LEWIS, S. (1998) Which atypical antipsychotic? *British Journal of Psychiatry*, **172**, 106–109.

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## Psychiatry, post-modernism and politics

Sir: Allan Beveridge believes medicine, and psychiatry in particular, to be vulnerable to a post-modernist critique if it is founded upon the belief that there is a "single, objective, verifiable reality" (*Psychiatric Bulletin*, September 1998, **22**, 573–574). This may be the case, but the question that is perhaps more true to the origins and traditions of medicine, as opposed to many of the natural sciences, is less 'what is' than 'what works'. Employing a technique that ameliorates or abolishes the features that are troubling the patient, and being concerned with evidence that this is in fact the effect of the treatment, bypasses the critique. This argument is tacitly accepted when post-modern theorists become seriously ill; concerns about treatment effectiveness quickly take precedence over disagreements regarding the possibility of accurately representing reality.

Beveridge highlights the potential for a post-modern approach leading to a better understanding between the psychiatrist, who attributes disease to neurotransmitters, and the patient, who complains of poor housing and poverty. Such an approach might be expected to facilitate a widening of the scope of medical/psychiatric interest to include areas politicians might prefer remain unscrutinised, but this is not necessarily the case. Indeed, post-modernism has itself been accused of engendering political hopelessness and inertia, or of being a product of perceived political impotence (Chomsky, 1994). When there are so many equally valid ways of formulating a problem, how can a particular solution be implemented with conviction?

## Reference

- CHOMSKY, N. (1994) *Keeping the Rabble in Line: Interviews with David Barsamian*. Monroe, MI: Common Courage Press.

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## Patients' knowledge of their lithium therapy

Sir: I was interested to note the results of knowledge of lithium treatment among patients attending a lithium clinic (Anderson & Sowerbutts, *Psychiatric Bulletin*, December 1998, **22**, 740–843). I conducted a similar study in 1995 on patients in an area without a lithium clinic (Oxford). I recruited recently discharged inpatients and day patients on lithium. I devised a questionnaire on knowledge of lithium and sent it to 28 people.

I received 16 replies. In my sample eight had received a lithium information leaflet, five reported having received no information, the remainder having been informed by their doctor. None of the patients correctly identified the signs of lithium toxicity, only one knew of any drug interactions and none knew what other factors could affect lithium levels, although two women recorded pregnancy as a reason to contact a doctor or community psychiatric nurse. The study had obvious limitations, but the 16 respondents clearly showed an inadequate knowledge of the most dangerous aspects of their treatment.

It has been suggested that the most appropriate setting for lithium surveillance is a specialised lithium clinic (Guscott & Taylor, 1994). However, this can be difficult to organise with the move towards sectorised clinical services. The resultant idiosyncrasies of lithium management could lead to inadequate knowledge among patients and poor compliance. I suggest the need for a national protocol of minimum standards of education on treatment for patients which involves multimedia educational techniques as well as regular re-checking of information retained.

## Reference

- GUSCOTT, R. & TAYLOR, L. (1994) Lithium prophylaxis in recurrent affective illness. Efficacy, effectiveness and efficiency. *British Journal of Psychiatry*, **164**, 741–746.

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