



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.

M. F. Bristow South West London & St Georges Mental Health NHS Trust, Cheam Resource Centre, North Cheam, Surrey SM3 9DL

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/neurophysiology, 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 extrapyramidal 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.

Clive E. Adams Co-ordinating Editor, Cochrane Schizophrenia Group, 15 Hyde Terrace, Leeds LS2 9LT

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.