Consultant participation in therapeutic management

Sir: The articles by Haigh (Psychiatric Bulletin, October 2002, 26, 380–382), Holmes (Psychiatric Bulletin, October 2002, 26, 383–385) and Davenport (Psychiatric Bulletin, October 2002, 26, 385–388) on the therapeutic management of the acute ward, were timely. It is not easy to manage a busy ward in this fashion but with determination from the consultant and a senior nurse, it is possible and very rewarding.

Contemporary registrar training does not always prepare well for this role. I was lucky to have the benefit of being Douglas Bennett’s registrar in the 1960s when I was introduced to this style of management. I then went on to be a co-therapist in an outpatient psychotherapy group with Heinz Wolff. Heinz was a very active therapist and this is more what is needed in a ward group where practically all the patients, if given the option, would rather not be there. In any case, the purposes of the ward group are different from those of outpatient psychotherapy. At their most basic they are a reason for the patient to get out of bed in the morning and an occasion for recognising the existence of each individual. It is important not to exclude a difficult and disruptive patient. Often in the setting of the group, they can respond remarkably well, which makes it a positive experience for all. The group is also a highly efficient way of using staff time, when all the patients attend the group. It is also possible to include patients on special observations, which turns what is usually a tedious task into a therapeutic experience. It is not easy to maintain the group if the group is a daily activity, well which makes it a positive experience for all.

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Service provision for gender dysphoria

Sir: I was pleased to read the article by Murjan, Shepherd, and Ferguson (Psychiatric Bulletin, June 2002, 26, 210–212), highlighting the variability of services available for the assessment of individuals with gender dysphoria.

However, I am concerned that their conclusions are not supported by the data provided. They state that “most transsexual people have access to NHS services for the treatment of gender dysphoria”. The results presented are that 79/120 (65%) health authorities replied to the survey confirming that they had a commissioning policy, either from local or recognised national centres. It is not stated whether patients were actually referred or seen within a reasonable amount of time. At least one health authority imposes a 5 year “residency criterion” in their area for referral to a specialist service, despite the High Court ruling in A, D and G v NW Lancashire Health Authority, Court of Appeal 29 July 1999, Case Nos. QBC 1999/0226/4, 0228/4, 0230/4.

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In their assessment of services provided to transsexual patients, the authors relied on the 5th edition of the Harry Benjamin International Gender Dysphoria Association Standards of Care for Gender Identity Disorders (1998). In doing so they omitted to refer to the current edition which is the 6th edition, (2001), with revised standards and a modern approach favouring flexibility, rather than uniformity of provision. The current edition concludes that “in some patients, hormone therapy alone may provide sufficient symptomatic relief to obviate the need for cross-living or surgery”.

The unfortunate consequences of the authors’ use of the old edition are manifest in two ways. First, their implicit criticism of a Health Authority for commissioning hormonal therapy without surgery for transsexual people; and