

been actively engaged in medical audit for one year. Brief introductions to some of the principles and ideas that we have employed were presented by Johnston at the Section for Psychiatry of Mental Handicap meeting in March 1990 and published in September 1990. I write now to encourage further those not already actively engaged in medical audit that this can be a very worthwhile process. One year since monitoring the number of anticonvulsant medications prescribed to the in-patient population, this situation has been reviewed. Across all the districts in our group, not just those reported in the previous paper, a reduction in the number of anticonvulsants received by patients occurred. Some patients have successfully had all anticonvulsant medication withdrawn. Further, anticonvulsant medication which was thought to be inappropriate or outmoded has been converted to more acceptable medication. This has not, however, been performed at the expense of seizure control.

The simple procedure of counting and recording the anticonvulsants prescribed, followed by rationalisation of the prescription of such anticonvulsants has, overall, produced a reduction in the total number of anticonvulsants prescribed, the combinations of anticonvulsants prescribed, and an updating of such therapy.

This was the first step in our medical audit of those patients receiving anticonvulsant therapy for epilepsy. This year we have further extended the audit process to include all patients on anticonvulsants and have set up and designed standards which we consider to be minimal in the monitoring of anticonvulsant medication.

We have recognised and highlighted that the next stage may well be the monitoring of seizure control, this being an inexact and unreliable situation at present.

It is only when we can draw together the results of the various small audit exercises that we will be able to say with any degree of certainty that the patients receiving anticonvulsant medication for whom we provide the clinical care receive what we consider to be the most appropriate anticonvulsants and that these are monitored adequately for the benefit of the patient.

Collecting data for medical audit is undoubtedly a time-consuming task. The presentation of audit data is difficult. However, the retrieval of last year's data for comparison makes the previous difficulties seem minor inconveniences. Our experience has highlighted the need for simple medical audit, the data for which can be relatively easily collected and tabulated, and centrally stored safely so that additional aspects of the clinical problem which may be similarly audited in a small way can be built on subsequently.

Since our audit exercise we have been able to write clear operational guidelines which we hope will be

applied not only within our hospital settings, thereby maintaining what we consider to be good standards of care, but also which could be applied to populations of people in the community.

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References

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Out-patient follow-up clinics

DEAR SIRS

In reply to Drs Davidson & Pooles' letter (*Psychiatric Bulletin*, June 1990, **14**, 371–372), our study may be adequate enough to describe the workload of a registrar follow-up clinic, but is not necessarily representative of other clinics held in the hospital studied. The thrust of our paper was that this is a widely used resource where little is known of the characteristics of attenders and non-attenders.

Davidson & Poole are surprised that we do not emphasise that 89% of patients suffered from schizophrenia or manic-depressive illness. However, in inner-city catchment areas patients with a diagnosis of schizophrenia are known to be over-represented by social drift. Both diagnostic groups have chronic, relapsing illness and will by self-selection inevitably be further over-represented in clinics.

This is a vulnerable group and while there are limitations to such clinics, this does not mean that an inadequate standard of care is offered or that Davidson & Pooles' suggestions will improve matters. Their statement that "maximum continuity of care and expert input cannot be found in a registrar clinic . . ." is a sweeping generalisation without any supporting data. This surely depends on the caseload of the catchment area, type of patients seen, expertise of the registrars and the amount of supervision given by senior staff to registrars. We cannot comment on the present organisation of clinics in Liverpool, but in the district studied all patients who were particularly difficult to manage or vulnerable were usually seen by the consultant and senior registrar, supervision was readily available, and at times of change-over the more difficult patients could be added to the senior lists. Non-attenders were followed-up wherever possible by a number of means including CPN, social worker and domiciliary visit.

Davidson & Poole do not state who are "trained members of the permanent staff" (we take this to mean consultants) nor whether they feel some or all of the 89% identified should be cared for by such

staff. If this is what they really mean their suggestions will prove difficult to implement for several reasons.

(a) Based on statistics available for our district this would cause a substantial (150–200%) increase in the number of patients needing consultant out-patient care and a corresponding (and very expensive) increase of consultant numbers (a figure some way ahead of that anticipated in *Achieving a Balance*). Without such consultant expansion, consultants will be permanently tied to out-patient clinics and the quality of other aspects of care given by consultants would be compromised.

(b) If all or most of this vulnerable group were under consultant care how will registrars gain necessary skills to manage this group confidently before they become senior registrars or consultants where greater clinical autonomy and less supervision may be expected?

(c) The main drawback with traditional out-patient care which we addressed in the paper is the often high default rate. There is no evidence to suggest that this should necessarily be lower in consultant-based care. Audit of this type of service should be a higher priority as the traditional model appears to be inefficient.

Our study demonstrates that there are few diagnostic (and therefore vulnerability) differences in attenders and defaulters. The priority development in this form of care should be to improve its efficiency by reducing the high default rates seen. It may be that this is due to the shortcomings of the actual method of care, rather than the grade of medical officer involved. Apart from audit of traditional models of out-patient care, we feel there should be more research on other methods of follow-up, e.g. transfer of out-patient clinics into general practice settings.

We would be grateful to hear from other colleagues who have studied this form of care or alternative methods of follow-up of chronically mentally ill patients.

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DEAR SIRs

In response to the letter from Drs Shah and Lynch, the key element in our original letter refers to the fact that registrars usually spend only six months in one post but they have omitted this phrase from the quotation they give.

The aim of our letter was to highlight the need to look at both service *and* training implications of current changes in service provision. We feel that this should be debated widely in the College and this view is supported by recent correspondence to the *Bulletin* (November 1990, 14, 681–682) as well as by Drs Shah and Lynch.

We do not believe that brief letters in the correspondence section can do more than highlight this problem. We are sure that this is a topical issue and that many options are being considered. We would be happy to describe our approach as part of widening such a discussion but we would not suggest that it is anything other than one possible way to tackle the problem.

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Medical students' participation in psychiatric out-patients' clinics

DEAR SIRs

Attendance at, and participation in, out-patients' clinics is an essential part of the training in psychiatry offered to medical students. It provides an opportunity for the students to assess relatively cooperative patients whose symptoms have not been modified by prior treatment. Unfortunately, there are problems surrounding this participation.

Many students find it distressing to be party to the mass interview of a patient and feel that some consultants are unsympathetic and inconsiderate in making patients endure these consultations.

Patients compelled to repeat their history before a 'crowd' of students have been known to change their stories, to the detriment of their assessment. An alcoholic man gave a perfect history of his condition to one student, but insisted (to the student's embarrassment) that she had misunderstood him when she presented his drinking history to the group.

Going through the initial clerkship by one student, and the subsequent presentation to the consultant and the group, can take up as much as three hours, further undermining the benefits of the consultation.

The needs of the patient and the students could be met equally if the new patient is clerked by a student for no more than one hour. The student and the patient then go in for a discussion for 15–20 minutes, with the consultant. The essential points are assessed and arrangements made for the care of the patient who, after no more than 1½ hours, goes home.

After the patient has left, the rest of the medical students join in and have a fuller presentation of the case, with discussion.