following reception than other medications. In my view, this issue highlights the ongoing fault lines of professional disdain and mistrust towards psychiatry among our other medical colleagues.[3–5] Solving this problem will have to go beyond the platitude of the 'additional training required' and will necessitate a significant drive to improve the image of psychiatry as a credible medical discipline.

1 Hassan L, Senior J, Edge D, Shaw J. Continuity of supply of psychiatric medicines for newly received prisoners. *Psychiatrist* 2011; **35**: 244–8.

2 Offender Health Research Network. *An Audit of Medication Prescribing Practices following Imprisonment*. OHRN, 2010 (www.ohrn.nhs.uk/resource/Research/MedicationAuditOHRN2010.pdf).

3 Craddock N, Antebi D, Attenburrow MJ, Bailey A, Carson A, Cowen P, et al. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.

4 Brockington IF, Mumford DB. Recruitment into psychiatry. *Br J Psychiatry* 2002; **180**: 307–12.

5 Storer D. Recruiting and retaining psychiatrists. *Br J Psychiatry* 2002; **180**: 296–7.

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Emotional doctors in the house!

Stanton *et al*[1] have produced a thought-provoking study on emotional intelligence, and, in a selfless move which I hope will add to their findings that psychiatrists score highly on social responsibility scale, I would like to correct their assertion that Sir Lancelot Spratt was a product of the *Carry On* films. He was in fact a recurring terror in the *Doctor in the House* series.

1 Stanton C, Sethi FN, Dale O, Phelan M, Laban JT, Eliahoo J. Comparison of emotional intelligence between psychiatrists and surgeons. *Psychiatrist* 2011; **35**: 124–9.

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Change for better or worse – New Ways of Working?

The factors psychiatrists feel induce and relieve stress in the course of their working lives, as presented in the paper by Rathod *et al*,[1] are interesting and thought provoking. In our opinion, however, the findings are interpreted idiosyncratically, just possibly influenced by the first author's role as consultant in a crisis resolution and home treatment team.

The authors highlighted the finding that functional teams were rated as reducing psychiatrists' stress levels, applauding the positive effects of National Health Service (NHS) changes. Whereas consultants reported stress as a result of working across interfaces and from loss of continuity of care, Rathod *et al* write: 'It is the authors' opinion that it is the consequences of these changes . . . that are causing the stress rather than the changes *per se*'. So the changes are good, it is just their consequences that are bad? In fact, 21.4% of consultants in the study listed the creation of functional teams as stress reducing, whereas 49% and 44% respectively cited working across interfaces and loss of continuity of care as factors that caused stress.

New Ways of Working was introduced principally with the aim of reducing stress among psychiatrists. The possibility that the resultant loss of continuity of care, bemoaned both by patients[2] and by psychiatrists[3] for its negative clinical effects, may have actually increased psychiatrists' stress levels does seem to be a most unfortunate outcome.

The counterbalance to stress in most areas of work is that of job satisfaction, a point that Rathod *et al* do not address. Especially at a time when recruitment into our specialty is falling, the point is an important one. For many practising psychiatrists, it is the continuity of responsibility for our case-loads of patients that provides job satisfaction and moderates stress.

If service changes have been associated with increased stress among psychiatrists and with reduced patient satisfaction, both against a backdrop of a crisis in recruiting doctors into psychiatry, is it perhaps time to think again?

1 Rathod S, Mistry M, Ibbotson B, Kingdon D. Stress in psychiatrists: coping with a decade of rapid change. *Psychiatrist* 2011; **35**: 130–4.

2 Singhal A, Garg D, Rana AK, Naheed M. Two consultants for one patient: service users' and service providers' views on 'New Ways'. *Psychiatrist* 2010; **34**: 181–6.

3 Dale J, Milner G. New Ways not working? Psychiatrists' attitudes. *Psychiatr Bull* 2009; **33**: 204–7.

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Sexual Offences Act – issues where both individuals lack capacity

Psychiatrists, especially those working with people with intellectual disabilities, may encounter situations where two individuals who engage in sexual contact both lack capacity. It may be that the contact is consensual, but it could be argued that the individuals are committing an offence, as both parties lack capacity. However, to construe the act as an offence would be tantamount to asserting that individuals lacking capacity should not engage in sexual contact, and this could be seen as an infringement of their human rights.

There is no simple answer to such a situation. The sexual contact might be grounds for initiating safeguarding procedures if there is a power imbalance between the concerned persons. Where the act is consensual, clinicians are faced with a dilemma and need to balance the patients' autonomy and rights against their professional duty of care to protect patients. A best interests meeting might help to resolve the issues and arrive at a consensus of opinion.

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Who should manage metabolic dysregulation?

Bainbridge *et al*'s paper[1] on general practitioners' (GPs') attitudes on who should manage metabolic dysregulation associated with antipsychotics is interesting, topical and important, although we would like to make a couple of comments.

First, regarding the methodology of the study, the choices for the clinicians were unnecessarily polarised where only one option out of four (A–D) could be chosen. It is thus not surprising that the views somewhat reflected this false polarisation. This may be an indicator of the limitations of a questionnaire-type study, so it would be fascinating to conduct a more qualitative type study in which some of the issues could be explored and examined in depth.

Our personal view is that the joint approach which incorporates both options A and B (that is, psychiatry referring to primary care, as well as providing simple management around nutrition and exercise) could have been another option. This echoes the values behind the National Institute for Health and Clinical Excellence (NICE) guidelines for schizophrenia,[2] where joint monitoring (and, by extension, management) of physical health is emphasised in their recovery promoting statements.

Second, it is worthwhile to look at current guidance on prescribing – the *British National Formulary* (BNF) clearly states that any prescribing of medication should be discussed – including the risks and benefits – with the patient.[3] NICE also highlights this in a patient-centred approach to care.[2]

With these points in mind it is important to assume that whatever option is taken, there has been a discussion with the patient about the possible adverse effects of medication[4] and it would be interesting to explore what is said about who is responsible when such side-effects occur. Ideally, the patient ought to seek advice from the prescriber in the first instance. However, if the prescriber is the GP, some patients may find it easier to access their psychiatric team first, who would subsequently contact the GP on their behalf.

The backdrop to these comments is that we are a psychiatrist and GP who have, through our own efforts, come to the conclusion that real, effective collaborative working means face-to-face meetings. We look after a small 24-hour-supported placement in London, which houses 13 residents (mean age 49 years) whose disease is at the severe end of the mental health spectrum.[5] Usually, most residents will attend the surgery with the key-worker, although this is never guaranteed and sometimes there is the call for a home visit.

The level of morbidity is high. Currently, 54% of the residents have non-insulin-dependent diabetes and 70% have hypertension, with one resident having dialysis three times per week. Additionally, most smoke heavily and the mean body mass index of all residents is >30. The psychiatric team continue to reiterate advice on healthy eating, exercise and smoking cessation, whereas the GP practice initiates any necessary medication for metabolic dysregulation.

Since working together on the project we have increased flu vaccination rates every autumn (from 20 to 90%) and developed some innovative ideas regarding positive health promotion. For example, residents are invited to attend a walking group and we are currently attempting to engage a dietician specifically to give advice to both residents and staff.

We agree with Bainbridge *et al*'s conclusion that 'clearly defined roles for mental health services and primary care in the management of metabolic complications are of paramount importance'. However, we are of the firm belief that to delineate such roles there is no substitute for face-to-face meetings where patients are jointly discussed, monitored and managed.

1 Bainbridge E, Gallagher A, McDonald G, McDonald C, Ahmed M. General practitioners' attitudes on who should manage metabolic dysregulations associated with antipsychotics. *Psychiatrist* 2011; **35**: 213–5.

2 National Institute for Health and Clinical Excellence. *Core Interventions in the Treatment and Management of Schizophrenia in Adults in Primary and Secondary Care (Clinical Guideline CG82)*. NICE, 2009.

3 British Medical Association, Royal Pharmaceutical Society of Great Britain. *British National Formulary* (issue 61). BMJ Group and Pharm Press, 2011.

4 Mackin P, Thomas SHL. Therapeutics: atypical antipsychotic drugs. *BMJ* 2011; **342**: d1126.

5 NHS Lewisham. Health, Well-Being and Care: Lewisham Joint Strategic Health Needs Assessment. NHS Lewisham, 2010 (http://www.lewishampct.nhs.uk/documents/2331.doc).

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Correction

Obituary for Professor John Anthony (Sean) Spence. *Psychiatrist* 2011; **35**: 319. Professor Sean Spence was formerly Professor of General Adult Psychiatry, Sheffield University. The publishers apologise to Professor Peter W. R. Woodruff for this error.

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