the columns

correspondence

European Commission Green Paper on mental health

Professor Stefan Priebe (*Psychiatric Bulletin*, August 2006, **30**, 281–282) asks whether the European Commission Green Paper on mental health is a 'sign of progress or confusion'. It is a manifest sign of political progress and as such has been welcomed by the College (Royal College of Psychiatrists, 2006).

We must remember that the purpose of the Green Paper was to begin consultation for a future strategy. It is premature to expect 'achievable priorities and specific ideas', and off-the-peg solutions will not suit all member states. As first steps, a platform for exchanging expertise, greater coherence between information, research and policy, inclusion of mental health in the framework programme for research funding, and a more uniform approach to human rights seem to be realistic and valuable.

We must also understand the scope of responsibility of the European Commission, which includes health promotion, prevention and provision of information but not healthcare services. Hence the use of the broad World Health Organization terminology for 'mental ill health', and the emphasis upon a wide range of problems, many of which should not be considered as illnesses. Promotion of mental well-being necessitates collaboration between policy makers from health, economics, housing, immigration, criminal justice, employment and other departments. The aspiration is indeed to further the debate within political and commissioning circles – not to treat people who are not ill.

Priebe's reservations seem to result from confusion between the case for widespread promotion and prevention, and the specialised need for good treatment for those with established conditions. No problem!

ROYAL COLLEGE OF PSYCHIATRISTS (2006) *College Response to the European Commission Green Paper on Mental Health*. http://www.rcpsych.ac.uk/pressparliament/collegeresponses/parliament/responses/collegeresponsemay06.aspx

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The Hippocratic Oath: is it outdated?

Marzanski *et al* (*Psychiatric Bulletin*, September 2006, **30**, 327–329) highlight the shortcomings of the Hippocratic Oath in their survey of psychiatrists' attitudes. The Oath has become flawed for two main reasons.

First, it is outdated. It contains archaic, gender-specific language but, more importantly, it completely forbids abortion. Doctors in all regions of the UK widely support the provision of termination of pregnancy (Marie Stopes International, 1999) which is legel in Great Britain. Marzanski *et al* confirm unease with this principle of the Oath, although the standard responses on their Likert scale do not necessarily lend themselves to accurate representations of respondents' views on this and some other principles surveyed.

Second, the Oath has been superseded by adequate modern guidance and doctrine, which relate more closely to current practice and expectations of doctors. *Good Medical Practice* (General Medical Council, 2001) provides guidance to all UK doctors on issues of ethics and professionalism, and the *Declaration of Geneva* (World Medical Association, 2006) sets out 11 principles of medical practice in much the same manner as the Oath. Unlike the Oath, the *Declaration* does not mention abortion and includes pledges not to discriminate on racial, religious or other grounds and not to violate human rights or civil liberties. This latter pledge holds a special significance for our specialty, given the abuses that have been perpetrated internationally in the name of psychiatry.

GENERAL MEDICAL COUNCIL (2001) *Good Medical Practice*. http://www.gmc-uk.org/guidance/library/GMP.pdf

MARIE STOPES INTERNATIONAL (1999) *General Practitioners: Attitudes to Abortion*. http://www.mariestopes.org.uk/pdf/gps-attitude-report.pdf

WORLD MEDICAL ASSOCIATION (2006) *Declaration of Geneva*. http://www.wma.net/e/policy/c8.htm

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First on-call psychiatrist: resident or non-resident?

Mason *et al* (*Psychiatric Bulletin*, September 2006, **30**, 329–333) described the first on-call activity of senior house officers. We have differing views about whether the first on-call psychiatrist can function as a non-resident. Medical problems in psychiatric in-patients requiring urgent attention (such as chest pain and falls) do not always necessitate transfer of the patient to a medical/accident and emergency setting. Deciding whether to transfer a patient can be difficult without proper physical examination and relevant investigations. A resident doctor would speed up this process; any delay in such situations can compromise patient care.

There are certain clinical situations (such as agitation not responding to de-escalation) when a rapid response is necessary if patient and staff safety is not to be compromised. The effects of delay in such a situation are not easily measurable and Mason *et al* did not attempt to measure this. Hence the conclusion that 'there was no evidence that a resident doctor increased patient safety' is not justifiable.

Serious medical emergencies requiring rapid responses are thankfully rare, but equally inevitable. Such a small-scale study raises the question of a type II error.

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Monitoring the physical health of psychiatric patients on psychotropic drugs

Dr Tarrant highlights the risk of developing diabetes on antipsychotic medication and the need for monitoring of blood glucose (*Psychiatric Bulletin*, August 2006, **30**, 286–288). Psychiatric patients also tend to have a higher prevalence of other independent predictors of cardiovascular

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