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Copying letters to patients

The articles by Nandhra *et al* (*Psychiatric Bulletin*, February 2004, **28**, 40–42) and Lloyd (*Psychiatric Bulletin*, February 2004, **28**, 57–59) usefully discuss patients' reactions to having copies of letters about them, but how widespread this practice is already might have been underestimated. For example, routine health insurance check-ups, as carried out by BUPA, usually result in a summarising letter to the patient.

However, it was disappointing not to see any attempt in these articles at equating the sending of letters with getting patients better from their illnesses. For example, while patients seem to like receiving the letter, which is not surprising, does this process improve compliance, does it reduce Did Not Attend rates, or does it reduce subsequent use of the Mental Health Act 1983 even in patients with severe psychosis? These would be useful questions to ask, because clinical effectiveness should surely be at the forefront of practice innovation.

There also seems to be little recognition of the secretarial burden. Not only are extra letters having to be posted and sent, but is it not more likely that the wrong information might reach the wrong patient, generating difficult complaints? Given the 20% turnover of general practitioner (GP) patients in inner London (indicating high degrees of transiency and address changing), this will be a particular problem in urban areas. How do we know who opens letters in people's homes? Stigma, abuse and curiosity are unfortunately part and parcel of mental illness, while the problems of language and jargon, as well as the withholding of some aspects of information, may also cause complications.

Should all this not really be the province of the GP? It is the GP who initiates the consultation, and it would genuinely be a useful exercise for the GP's referring letter to be copied to the patient – or even composed with the patient in the room – so that all relevant information was included. Given the quality of some GP referral letters, this in itself could enhance clinical communication. Likewise, given that the out-patient clinical letter is sent to the GP, why not let the GP discuss the letter with his/her patient, thus avoiding the risks of wrong addresses, mis-sent enclosures, unexplained jargon and omissions of information by clinicians concerned about confidentiality etc. It is after all meant to be a 'primary care-led' service, and GPs are much more likely to be aware of the broader social and family issues relevant to a particular patient's capacity to understand and deal with health information.

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Consent Quiz: how well would you do?

We presented Rob Potter's consent quiz to the child and adolescent mental health team in Ipswich, in the context of a regular teaching slot attended by the different professionals of the multi-disciplinary team.

This included a brainstorming exercise, identifying those already familiar with the quiz and asking the others to complete the questionnaire anonymously, including demographic details. The paper (*Psychiatric Bulletin*, March 2004, **28**, 91–93) was then presented with the relevant literature (Shaw, 2001).

Seventeen professionals, except 2 who were familiar with the quiz, completed the questionnaire. Five out-patient nurses, 4 psychologists (1 trainee, 1 assistant, 1 a-grade, 1 consultant), 3 consultant psychiatrists and 6 professionals from other disciplines such as social work, occupational therapy and primary mental health workers participated. The average time they had been in their current posts was 5.5 years (1 day to 20 years), and they had been professionally qualified for an average of 12 years (not yet qualified to 33 years). Six participants see emergencies when on call, and gave correct responses in 46%, those who supervise the professional on call gave a correct response in 70% and those who do not see emergencies gave a correct response in 41% of the questions. The nurses gave a correct response to 58% of the questions, the psychiatrists 70%, the psychologists 42.5% and the others 50%. The overall correct response rate was 48%.

The results of the quiz done in Ipswich are comparable to the results of the survey when used in Mid Glamorgan. There is a need for professionals to familiarise themselves with the different aspects of the law. Tackling this complex field, by using a quiz, can be an interactive and effective way of teaching these salient aspects. We also see potential for an audit process, for example by modifying the questionnaire and then repeating the exercise following an adequate time interval.

SHAW, M. (2001) Competence and consent to treatment in children and adolescents. *Advances in Psychiatric Treatment*, **7**, 150–159.

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Primary care for psychiatric in-patients

The article by Welthagen *et al* (*Psychiatric Bulletin*, May 2004, **28**, 167–170), regarding the provision of a primary care service for psychiatric in-patients, was a useful reminder of the importance of addressing physical issues in persons with mental disorders. In Australia, this has been addressed by the Australian Council of Health Care Standards (ACHS), in conjunction with the Royal Australian and New Zealand College of Psychiatrists, who have developed a number of clinical indicators for use in psychiatric hospitals (Australian Council of Health Care Standards, 2003). These include the assessment of whether or not a patient has had a physical examination within 48 hours of admission.

At the Adelaide Clinic, a 64-bed private psychiatric hospital, a nearby group of general practitioners provides a 5 days a week primary care service at the hospital. In 1997–1998 there was compliance with the Clinical Indicator for physical examination within 48 hours of admission in 80% of admissions (Goldney *et al*, 1998),


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and this has risen over the past year to 95%. The ACHS provides data for 63 hospitals (both public and private) Australia-wide and the current overall compliance figure for this clinical indicator is 84%.

We note that the service reported by Welthagen *et al* provided assessment of 22% of patients after a median time of 22 days. Although their service is a step in the right direction, we believe it falls far short of an ideal assessment of the physical status of those with mental disorders.

AUSTRALIAN COUNCIL OF HEALTHCARE STANDARDS (2003) *Clinical Indicator Users' Manual 2004: Mental Health Indicators Version 4.* Sydney: ACHS.

GOLDNEY, R., FISHER, L., WALMSLEY, S. (1998) Quality improvement by use of Clinical Indicators in a psychiatric hospital. *Australasian Psychiatry*, **6**, 191–193.

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Bullying in the guise of career advice

Hoosen & Callaghan (*Psychiatric Bulletin*, June 2004, **28**, 225–227) identify many of the core features of bullying, including the common perception of the bullied individual that any action taken against the perpetrator will have a negative outcome. However, some forms of bullying are both less overt and more insidious.

Bullying in the form of career advice given either informally or formally during supervision, or the record of in-training assessment process, is harder to define but potentially just as damaging. It may affect performance, confidence and career progression. The authors identify supervision as supportive and indeed it can be, but it may also be one of the arenas of bullying. Senior clinicians naturally develop areas of expertise and bias toward certain activities, but awareness is needed of when advice moves beyond the appropriate (and perhaps directive) into an abuse of power, position or knowledge. For example, is it advice or bullying to suggest dropping union involvement from a *curriculum vitae* or to suggest dropping union activities altogether to secure senior posts in a chosen specialty? Essentially, the difference relates to whether the advice is sought and the consequences of not taking the advice.

While it is important to eliminate discrimination, harassment and bullying, it is also essential to differentiate bullying from legitimate and reasonable management of staff performance, and indeed from robust academic debate. However, given the negative effects of bullying is it now timely for the College to take an active role in eliminating it from the profession?

Declaration of interest

Dr Alastair Hull was on the Executive of the Junior Members Forum, of the British Medical Association which organised a symposium on 'Bullying, harassment and discrimination: still rife in the 21st Century NHS' in 2003.

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The objective structured clinical examination

I read with interest the recent letter regarding the Part I MRCPsych OSCE (Yak *et al*, *Psychiatric Bulletin*, July 2004, **28**, 265–266). However, I disagree with some conclusions.

From personal experience, most candidates feel that the OSCE does provide a fairer assessment of their skills, and I do not believe that the process of dissecting skills into an OSCE format is inherently harmful to the training of future psychiatrists. There are many important clinical skills that can be comfortably demonstrated within seven minutes; first-rank symptoms must be elicited before their context can be understood.

However, I would agree that too often, time itself becomes the major hurdle. This is quite contrary to clinical practice. If a difficult patient takes longer than expected in clinic, we would not rush them out, or end prematurely, but would take the necessary time and if required the clinic would overrun. The emphasis of the exam should not be different.

I am also concerned with the progression of the type of vignettes seen in the three OSCE exams so far. From the initial, very reasonable subjects, the cases are rapidly evolving into unreasonable scenarios. How many of us saw cases of temporal lobe epilepsy during our first year in psychiatry?

The OSCE exam, therefore, is less than perfect, but at least fair. I remain more concerned about the Part II examination, where candidates struggle against the hopelessness of the uncontrollable variables of patient and examiners. Perhaps it is the candidates, rather than the chief examiner, who adopt the mantle of Sisyphus (Tyrer & Oyebode, *British Journal of Psychiatry*, March 2004, **184**, 197–199).

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The use of 'drug dogs' in psychiatry

This 'opinion and debate' (Gordon & Haider, *Psychiatric Bulletin*, June 2004, **28**, 196–198) appeared in the *Bulletin* within weeks of our local site teaching a seminar on 'Safer Services'. Concurrently, our local paper's front page feature was entitled 'Sniffer dogs for St Luke's wards', and contained a photograph of and many quotes from our Chief Executive. I took the opportunity to circulate a brief questionnaire to attenders of our multi-professional site teaching. Nine questionnaires were returned, eight from medical staff and one from nursing staff.

Views about random visits from sniffer dogs and their handlers included those that it would be a waste of money, would create an atmosphere of fear and distrust, would be counter-therapeutic, and may be an embarrassment to those patients (and staff) identified by sniffer dogs. However, they would reduce illicit substance misuse and dealer activities, could prevent non-users being introduced to drugs, may have an educational effect by promoting 'zero-tolerance', and knowing who is using illicit drugs could inform prescribing for those patients. There were concerns about consequences such as implementing prosecutions and discharge of patients/dealers that may not be therapeutic. There was also concern that these measures may not actually work.

Views about airport-style metal detectors at unit receptions were also solicited. Responders thought that these may reduce or prevent weapons being brought into our units, but they would require constant manning by staff with search skills (females for females), would be very expensive to maintain, would be slow for large numbers of people entering the unit at one time, e.g. students, and inconvenient for people going in and out of the unit frequently, e.g. doctors. There were also concerns about having to empty pockets, and what would happen when weapons were found – disarming people may cause violence in itself.

'Would you feel safer at work with sniffer dogs and/or metal detectors in use?' The replies were five Yes, three No, one not answered; three commented that adequate staffing levels and presence of security guards would help to make services safer for patients, visitors, and staff, and one person suggested DNA and fingerprints of all patients should be taken!

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