

Court for the nomination of a nearest relative should then be considered.

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I am grateful to Ms Carol Thomas for advice about the Mental Health Act.

Central monitoring of clozapine

DEAR SIRs

McGilt & Anderson (*Psychiatric Bulletin*, July 1992, 16, 450) wonder if patients established on clozapine might eventually move to having their blood monitored by the local haematological service. In fact the Germans already do this as each clinician takes responsibility for his/her own monitoring. However, many Germans do not believe that clozapine is more risky than normal psychotropic drugs with regard to neutropenia and also that they use, in general, lower doses of clozapine and mix clozapine with conventional psychotropics.

I feel, as we have now nearly 50 patients who have commenced clozapine and two red alerts, that central monitoring is essential. One reason is to keep track of red alerts and ban the transient patient from being re-exposed, which could prove fatal. A second reason is that the Clozaril Patient Monitoring System (CPMS) has all the registered cases on computer analysis to enable early warning signs to be picked up. This may lead to more false positive neutropenias and increase the number of red alerts, but I think that the UK service is probably the safest in operation.

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Telemedicine child psychiatric consultations to under-serviced areas

DEAR SIRs

I would like to offer a brief report of a Canadian experience using telemedicine to offer child psychiatric and family assessments between the University of Western Ontario, London, and Woodstock General Hospital, Department of Psychiatry, using an interactive television link.

Weekly psychiatric consultations took place via the interactive television link between November 1984 and August 1985. This involved a child psychiatric team of a psychologist, social worker, psychiatric nurse and child psychotherapist, and myself acting as a consultant. New case assessments often combined with crisis interviews and follow-up reviews took place on a weekly basis. Approximately

every fourth week, an on-site visit allowed me to conduct an assessment with the team in person. While no patients or families refused involvement, there was a consensus between both patients and staff that live interviews are superior.

What was lost? While technically feasible to interview individuals or families, valuable diagnostic information was lost, e.g. unavailability of split-screen techniques prevented simultaneous views of the individual and family. Secondly, significantly less hypothesis generating took place among team members than during an on-site assessment. Thirdly, team members and patients experienced an "emotional distance" with the consultant in comparison to face to face contact. Thus while on-site visits were important in establishing rapport and developing team cohesion, they also appeared to contribute towards a negative attitude within team members towards the television link.

What was gained? The link provided adequate clinical assessments of a routine and crisis nature with a 50% reduction in the consultant's time because of reduced travelling when compared to on-site consultations. Patient acceptability was generally high.

In Ontario, and throughout Canada, there remains a severe shortage of specialist psychiatric consultation for the northern regions of the province. The use of telemedicine links with established psychiatric teams could allow the regular input of specialist psychiatric consultation without the need for the extensive travelling time. These services might combine with the presence of an on-site psychiatric resident, supervised by the psychiatric consultant via telemedicine link, who would become a member of the on-site team. This would also serve the function of exposing consultants-in-training to a first-hand experience of rural conditions while providing them with adequate consultant supervision. Hopefully, some of them would become interested in making a more permanent commitment to rural practice.

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Reactions to pregnancy: exacerbated by sexual abuse?

DEAR SIRs

I read with interest Dr Neilsons' account of her pregnancy (*Psychiatric Bulletin*, July 1992, 16, 442-443). For four of my patients, with bulimia nervosa and a history of childhood sexual abuse (CSA), news of my pregnancy had marked repercussions.

Case 1. Became distressed, recollecting her termination of pregnancy, and disclosed CSA. During the following sessions she became progressively more disinhibited and eventually hypomanic. This culminated in her doing karate kicks while saying, "You are so perfect, with your job, husband and baby asking me how I felt about my termination, I could have killed you". When I acknowledged her anger she accepted admission.

Case 2. Announced that she wanted to get pregnant too, "so we can have our babies together" and had been having unprotected intercourse. We were able to explore her wish to become pregnant, to keeping the therapy alive inside her and to identify with me, while on the other hand attacking me, by withdrawing from a drug trial she was participating in.

Case 3. Had recently disclosed CSA to her family. My pregnancy coincided with the breakup of her marriage. Earlier treatment had ended due to her therapist's pregnancy. She became depressed and suicidal, saying "I'm not important to you, you have a life and family of your own", and required admission.

Case 4. Had been abused by her brother. After hearing of my pregnancy she returned her medication saying that news of my pregnancy had cured her. She did, however, admit to being angry, "with men, it's all their fault", saying that as I had my baby to worry about I should not waste time on her. Despite interpreting her anger, she continued her "flight into health". On my return from maternity leave she represented.

My pregnancy, by reminding patients of their damaged sexuality, made them envious of my life and marriage. I was perceived as abandoning them, as perhaps their mothers did in not protecting them from abuse, leading them to demonstrate their neediness. A physician's pregnancy may be particularly traumatic for patients who have been abused.

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Need for support in developing clinical skills

DEAR SIRS

I greatly enjoyed the article 'The Doctor Patient Relationship and Psychiatric Out-patients' (Timimi, *Psychiatric Bulletin*, June 1991, 16, 425–427). The

author reminds us that no matter how straightforward or "biomedical" a clinical problem may appear, we ignore the subtleties of transference and counter-transference at our peril. This message is particularly refreshing at a time when psychodynamic principles and their advocates are so often displaced by the hegemony of biological psychiatry.

I was, however, concerned by the style in which this piece was written, and in particular the repeated implication that the author had arrived at these clinical insights in isolation. While accepting that Dr Timimi may be a gifted as well as a perceptive psychiatrist, the piece makes no mention of colleagues, either junior or senior. With the exception of an intuitive "flash" (as described by Balint) the author fails to identify the sources of any of the interpretations employed. The use of a private, rather than a work, address at the top of the paper further suggests a clinician working alone.

As psychiatric trainees we are under great pressure to undertake service commitments, initiate research, prepare for exams and apply for career posts, all in the space of a few years. In the midst of this we also seek to develop clinical skills which are necessarily very different from those of our medical colleagues. Above all we must learn to listen to our patients in the manner exemplified by Dr Timimi. It is highly misleading, and potentially dangerous, to suggest, however subliminally, that these skills can be arrived at intuitively or without supervision. Life for a psychiatric trainee is hard enough without being made to feel that one should be able to arrive at psychodynamic formulations unaided.

To develop clinical skills trainees require both peer support and the sort of supervision which incorporates both didacticism and an attention to interpersonal issues in the doctor-patient relationship. Without supervision such matters are likely to be overlooked; at worst they may lead to dangerous or pathological acting out on the part of both doctor and patient.

Dr Timimi is right to re-assert the case for psychodynamic thought in the routine care of 'general' psychiatric out-patients. All trainees must be encouraged to think about their relationships with patients, including both the positive and negative feelings evoked. To do so may result in anxiety and a sense of vulnerability: for this experience to be bearable and therapeutically productive there must be considerable support. That this support is occasionally not forthcoming (or worse still not sought) is inexcusable; that a fellow trainee should suggest that it is unnecessary is highly regrettable.

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