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There is, not surprisingly, nothing very surprising in all this, in that the majority of statements are straightforward, uncontroversial and what anyone would expect of a good doctor. Thus, examples of unacceptable practice include 'communicating poorly with others' and 'acting against the best interests of the patient'. Good practice by contrast involves such things as 'being open to peer review' and 'only signing documents when assured as far as possible that the information is correct'. The College's responses, in fact, are divided into good and unacceptable practice, by and large, and it would be surprising if any College Member really did not know these core principles. The sceptic might consider that there is an element of spoon-feeding here, but there are one or two more controversial statements.

For example, among the examples of unacceptable practice, under the section entitled the trusting relationship, is apparently the 'abuse of power relationships within the team and in the therapeutic alliance'. This seems somewhat subjective in its understanding, and one might ask why not simply use the term 'bullying', as is used in employment tribunals? Under the consent to treatment section it is suggested that unacceptable practice includes an 'unwillingness to recognise the importance of seeking advice when children are at risk'. But one might ask why not also seek advice when adults, the elderly or other individuals with specific disabilities are at risk? Others might ask what the phrase 'formative assessment' means in the context of teaching and training, and question what is meant by an 'overcritical attitude' towards trainees. Again, is this not somewhat subjective, in that because a trainee feels criticised is that going to be sufficient evidence for the trainer being deemed 'overcritical'?

This lack of specificity is also seen in Appendix 2. Thus there is a large differ-

ence in the range of items required for general adult psychiatry (10 bullet points) as compared to the psychiatry of learning disability (17 bullet points). The speciality of substance misuse requires skill in risk assessment and 'knowledge of the spectrum of effective pharmacological treatments', but the term risk assessment is not included in the general adult psychiatry section. By contrast, general adult psychiatrists are asked to develop good practice in understanding, prescribing and monitoring the side-effects of a range of pharmacological therapies. What is clear, in fact, is that a lot more work needs to be done on boiling down these specialist roles, since there is both a lot of overlap, a lot of bland generalisation and a lot of the somewhat obvious. For example, under the forensic section there is required 'an understanding and awareness of issues relating to ethnicity, culture, gender and sexual orientation', which is fine, but not specifically forensic. Psychotherapists are enjoined to undertake 'regular supervision of own work' (and why not for everyone?), while liaison psychiatrists must have 'knowledge of specific interventions'. This whole section needs radical review.

Overall, of course, this kind of booklet does need to be published, since at its core is a sensible summation of good practice. It would benefit from a co-ordinating and purifying editorial hand, and from trying to avoid the unnecessarily obvious (e.g. 'listen to members of the team') and the tendency towards being something of a wish-list ('ability to be decisive'). It is clearly the task of every thoughtful psychiatrist to read it, report his or her concerns, positive and negative, to the relevant division or faculty and for the College to refine it further for the future.

Trevor Turner Consultant Psychiatrist, East London and the City Mental Health NHS Trust

The historic importance of this innocuous looking booklet is easy to miss at first glance, despite the warning in the introduction that it will assist in the appraisal and revalidation of psychiatrists. Comparison with the GMC's *Good Medical Practice* on opposing pages shows not only the superiority of the GMC prose, but also that good psychiatric practice seldom deviates from that which is to be expected of any doctor. The need for integrity, honesty, respect for colleagues and personal probity is rehearsed in both documents, becoming repetitious and eventually tiresome in the one under discussion. Due attention is paid to the vulnerability of patients, especially those unable to consent and the need to ensure the rights and safety of children. There is occasional overkill: is it

really necessary to specify that a psychiatrist must achieve competence in taking a history and conducting an examination of mental state? Will cardiological guidelines specify competence in auscultation of the heart? Specialist sections offer their authors (committees?) golden opportunities to strut their stuff, reminding us that the College is unusual in recognising six or seven different types of psychiatrist. Psychotherapists forbid themselves from using treatments that lack sufficient basis in scientific evidence. If they are anything like the rest of us this should leave them plenty of time for continuing professional development! It is to the psychotherapists' credit that it is in their section alone that one finds reference to improper relationships with patients. Prohibition of sexual relationships with patients is never explicit but therapists should be 'sensitive to the psychological implications of transgressing boundaries e.g. through touch and/or self revelation'.

Scattered throughout the report is a litany of exhortations that have less to do with clinical competence than with straight delinquency. Thus, the good psychiatrist will, *inter alia*, cooperate with confidential enquiries, take due note of guidelines from various organisations and avoid making autocratic decisions, falsifying clinical notes or 'deliberately flouting regulations'. The only reference to the primacy of patient needs is a Delphic statement on p.13: 'the psychiatrist will be able to judge the ethical implications of management requirements and take appropriate action'.

The report is a radical departure from the traditional role of the College as the arbiter of standards of education and training, to one of social policeman who peers into every nook and cranny of the lives of psychiatrists. If the spin of this report proves typical of similar documents from other Colleges, some will think that Faustian bargains have been struck with a government determined to put doctors in their proper place.

Questions, the answers to which lie outside the scope of this review, inevitably arise as to how this report will be used, to what purpose and by whom. Wedded as it is to the GMC and clinical governance in the UK, its provisions cannot apply to psychiatrists in Ireland, where separate (and hopefully better) arrangements will be needed in keeping with emergent legislation. Only time will tell if these developments will strengthen psychiatric practice in these islands; possible benefits to patients are even harder to predict.

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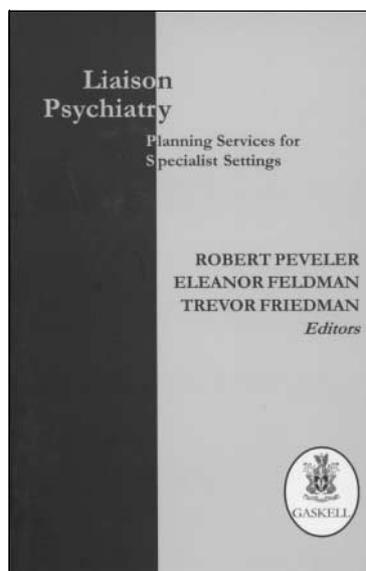
columns

encourage young doctors to take up psychiatry as a career it most definitely is not. Nobody wants to perpetuate the archetypal arrogant consultant, but this report loses the plot. Image matters. The image of the future psychiatrist created here is one of a doctor cum civil servant who must not only be competent, but must be all things to all women and men, provided only that the managerial boat is not rocked. It may be too much to hope that a second edition will remind us that psychiatry is a medical calling of high purpose and that the needs of patients are paramount; that any psychiatrist may on occasion be called on to speak out, even under threat, on behalf of patients or to support colleagues who do so. Blandishments here about good relationships within teams are all very well, but they gloss over the reality of final clinical responsibility and pale in comparison with the sheer punch of an earlier guideline: 'Life is short, and art long; the crisis fleeting; experience perilous, and decision difficult. The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and externals cooperate' (Hippocrates, 450 BCE). O tempora! O mores!

TJ Fahy The National University of Ireland, Galway

Liaison Psychiatry. Planning Services for Specialist Settings

Edited by Robert Peveler, Eleanor Feldman and Trevor Friedman. London: Gaskell. 2001. 216 pp. £30.00 (pb). ISBN: 1-901 242-47-1



As the focus of psychiatry has moved from hospitals to the community, the speciality of liaison psychiatry has developed to meet the psychological needs of patients in the general hospital. However, there is a risk that neither acute nor mental health trusts see liaison psychiatry as a priority in the competition for resources. Indeed, despite College recommendations, there are many general hospitals without a dedicated liaison psychiatry service.

This book is an important weapon in the battle for funding. The first chapter sets the scene by detailing how to compile a case of need for service development. This is supplemented by practical tips, such as the importance of personal and professional relationships in making a bid. I would also have welcomed an example of a (successful?) business plan to illustrate the advice given.

The book goes on to describe the role of liaison psychiatry in a number of general hospital departments, such as the pain clinic, intensive care unit and maternity wards. In discussing the high psychiatric workload of the accident and emergency department, David Storer refutes the misconception that liaison psychiatry is an 'optional extra'. Other chapters illustrate how this argument applies throughout the hospital.

The book goes further than its title in describing common problems faced by a liaison psychiatry service. I particularly recommend Eleanor Feldman's chapter on the use of the Mental Health Act and common law in the general hospital as a clear distillation of a potentially confusing topic.

The final chapter returns to the biggest obstacle to service development in liaison psychiatry, the issue of 'who pays?'. Both the mental health trust and the acute trust may see it as the responsibility of the other to fund a liaison psychiatry service in a general hospital.

The book highlights the danger that physical illness may be a barrier to general hospital patients receiving good mental health care. Despite having a high level of psychological morbidity, this is a neglected population. *Liaison Psychiatry* will help those who seek to fulfil one of the key aims of the National Service Framework for Mental Health in providing comprehensive mental health care for all.

Jim Bolton Lecturer, Department of Psychiatry, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE

miscellany

The Royal College of Psychiatrists is represented on the National Reference Group for a current project to develop national occupational standards in mental health. The project underpins the development of the mental health workforce in helping to raise standards in mental health and forms part of the National Service Framework for Mental Health. The standards will involve all staff groups in mental

health and all age ranges. Both health and social care staff are involved.

The project team are seeking feedback on the standards and also to involve psychiatrists in the field trials. There will also be web-based consultation from July 2002 and consultation events in January 2003. The project team would welcome the involvement of psychiatrists from as many areas and care settings as possible.

If you would like to be involved in the project or to receive regular information and comment on draft standards please contact, by e-mail, MillerWestLtd@cs.com. If you wish to have a more general conversation about the project please contact Karen Hardacre, Project Manager, on e-mail, Hardacre9857213@aol.com; or by tel, 0117 909 6273.

forthcoming events

Keele University, Department of Psychiatry, would like to announce the **Diploma and MSc courses in general psychiatry** commencing September 2002. These are part-time courses for registered medical practitioners. The diploma is suitable for affiliates of the Royal College of Psychiatrists,

general practitioners and all non-training grades and provides an overview of current research and practice based on the MRCPsych Part I examination syllabus. The MSc is for students who achieve a pass in the Diploma, have gained Part 1 MRCPsych or have a non-medical degree or equivalent professional experience. The

MSc is a 2-year course based on the MRCPsych Part II examination syllabus and all students are allocated a personal academic supervisor. For further details on both courses please contact Mrs Tracy Podmore or Miss Louise Alston, Departmental Secretaries, Department of Psychiatry, Harplands Hospital, Hilton