Correspondence

Routine enquiry for domestic violence is not enough

We read with great interest the paper by Morgan *et al*[1] on the prevalence of domestic violence and acceptability of clinical enquiry about abuse among female psychiatric patients. This study is highly topical, as our own review of the academic literature identified a dearth of research on prevalence of domestic violence in psychiatric settings and low rates of staff detection in routine clinical practice, particularly in the UK.[2] Morgan *et al*'s paper reported that the majority of patients sampled perceived clinical enquiry about domestic violence as acceptable. This finding, alongside high reported prevalence rates, led the authors to advocate routine enquiry about domestic violence by mental health professionals.

However, although our review found that the introduction of routine clinical enquiry in mental health services is associated with an increase in clinician identification of domestic violence, we do not believe that sufficient evidence currently exists to justify its implementation, unless it is introduced with training on how to ask, and is carried out with a referral and care pathway that can address the domestic violence. As well as Morgan *et al*, we have highlighted that, to date, research on the effectiveness of screening for domestic violence has not found evidence that enquiry leads to reductions in patient morbidity. Furthermore, routine enquiry is not a benign intervention and can lead to adverse consequences.[3] The report from the Department of Health Violence Against Women and Children (VAWC) National Health Service (NHS) taskforce[4] has also stressed the importance of prior clinical training and care pathways for domestic violence in ensuring efficacy of routine clinical enquiry. The Department of Health delivered an NHS awareness-raising campaign to coincide with End Violence against Women Day on 25 November 2010. This has led to support for primary care trusts and NHS trusts to raise the profile of VAWC locally. We hope that all mental health trusts will take advantage of the associated resources that have been sent to all trusts to raise awareness among staff and their local communities to address this highly prevalent issue for our patients.

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The heart of psychiatry

Craddock *et al*'s[1] attempt to define the core expertise of psychiatry is timely and welcome, but disconcertingly incomplete. Ethics, history and philosophy are no less central to the psychiatrist's craft. We have, after all, chosen to care for the only organ in the body that can vote.

Ethical issues arise all over medicine, but in psychiatry they abound. Issues of agency, belief and capacity, daily juggling the paradox of coercion and compassion, define much of our practice. No other branch of medicine has an entire legal statute devoted to it.

History is just as crucial. Ideas of illness, suffering and disease change constantly with the values and wisdom of the times and awareness of the progress of ideas over time is essential to the refinement of our practice. Medicine privileges us with a chance to study this within a living system of art and science, 3000 years in the making.

The importance of these skills is evident in doctors' relationship with society. Upon qualification, we receive honorary doctorate for nothing more than a bachelor degree (not unlike an increasing number of psychological therapists). Our title acknowledges that we have chosen to go where others fear to tread; severe mental illness is one of the most perplexing matters of all.

An omission of these issues from any definition of our craft may explain the difficulties that psychiatry apparently faces today.[2] Much of the concern about mental illness over the past two decades has centred on the ethics of coercion in risky cases and transgressions of the indefinable border between illness and 'healthy' distress. Psychiatry, practised properly, with its unique ability to evaluate past and present; brain, mind and body; culture, danger and bus pass[3] brings a clarity to these debates that none can rival.

This view appears anathema in a culture that places such heavy emphasis on consensus and certainty. The measures, goals and guidelines that abound in modern practice are symptoms of this. Against such apparent certainty, more subtle – and far more important – values become ever harder to define, but we omit them from our accounts at our peril.

These are cynical times and, as Oscar Wilde reminded us, a cynic is someone who knows the price of everything and the value of nothing.

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Improving outcome through patient satisfaction

Thank you to Dr Whelan and colleagues for their constructive comments[1] regarding the patient satisfaction scale, PatSat.[2] The idea for this scale sprung from years of using home-made scales for the yearly appraisal in a flawed attempt to measure the individual doctor's performance in the eyes of the patient. PatSat is therefore uniquely focused on the relationship between the clinician and the individual patient.

As Whelan *et al* correctly point out, the patient/doctor relationship is only a part of a patient's overall satisfaction with the service, but PatSat provides an evidence-based fundament for the individual clinician to learn about the relative strengths and weaknesses of his or her practice. The idea is that the clinician then can, through supervision, target areas that need further improvement and build on his or her stronger points.

Whelan and colleagues also allude to the importance of treatment outcome and its possible relationship with patient satisfaction. In spite of inherent problems with patient satisfaction questionnaires, such as the 'ceiling effect' (patients often scoring their clinician at the very high end of the spectrum) and poor response rates, the majority of the existing literature on this issue points to a strong correlation between outcome and patient satisfaction, especially with the individual clinician.[3]

The next step would be to investigate the correlation between commonly used, validated rating scales, e.g. the Hamilton Rating Scale for Depression (HRSD) and the Positive and Negative Syndrome Scale (PANSS), and patient satisfaction. In the PatSat scale the clinician has a direct way of testing and re-testing his or her personal impact on patients and the hope is therefore that this will provide an important avenue to improving outcomes for patients.

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What makes a good psychiatrist?

We welcome the restatement by Craddock *et al*[1] of the depth and diversity of 'added value' that the psychiatrist brings to mental health services.

In 2007, we undertook a standardised survey of the views of psychiatrists, mental health nurses and patients on what were the key attributes a psychiatrist should possess, which we entitled 'What makes a good psychiatrist?'

Overall, 244 psychiatrists, 70 nurses and 86 out-patients from across Scotland completed the survey. The top four key attributes to being 'a good psychiatrist' identified by the survey were different for the three groups.

Psychiatrists ranked clinical knowledge as the most important attribute (47.5%); 'communicates clearly' came second (20%), 'interested in people' third (19%) and 'honest and trustworthy' fourth (18%).

Top four attributes identified by nurses were: approachable (29%), clinical knowledge (27%), communicates clearly (24%) and good listener (14%).

For patients, the ranking was different still: good listener (41%), approachable (25%), treats patients as equals (23%) and non-judgemental (16%).

There are echoes of various guideline documents in these results (e.g. *New Ways of Working*, *Good Medical Practice*) and of a similar survey from Ireland.[2] Clearly, communication skills and individual values and attitudes are important, as is clinical knowledge. We believe that the patients did not rate clinical knowledge highly as they simply assume it to be there, even if the depth of general medical knowledge is not always appreciated. All three groups questioned did not feel that interests outside of psychiatry, or being well presented, were important professional attributes.

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Are crisis resolution teams toxic?

I read with interest the paper by Forbes *et al*,[1] which investigated the impact of a crisis resolution service. I am intrigued by their finding that the introduction of the crisis service was followed by an unexpected increase in the absolute numbers of patients detained under the Mental Health Act. In their discussion a number of possible explanations are explored. However, I believe there is one possible explanation, which is not fully discussed, although it is perhaps hinted at in the clinical implications section of their abstract. This is that the intervention might have a negative impact on some patients.

This is now the third study to find this association,[2,3] with only one group failing to replicate it.[4] Tyrer *et al*[3] explicitly and at some length discuss the notion that negative effects on some patients of this type of service are one of the most plausible explanations for the increase in compulsory admissions. Furthermore, they suggest that any benefit from crisis