Correspondence

The Approval Exercise—constipated chaos?

DEAR SIRS

The Collegiate Trainees Committee was dismayed to see Dr Launer's criticism of the College's Approval Exercise (*Bulletin*, April 1984, **8**, 74–75) and welcomed Professor Rawnsley's reply (*Bulletin*, July 1984, **8**, 139).

The CTC believes, however, that Dr Launer's letter contains a confusion that requires further comment. He claims that 'there is no proven correlation between the College rules for accreditation and a good working unit' but, in the Committee's view, such a correlation should not be sought as this would attempt too close a link between two separate issues, those of education and service provision. The Approval Exercise is concerned with educational standards, and in the CTC's view it would be unacceptable for the hands of the Approval Exercise to be tied by considerations of service provision.

Nevertheless, the Committee is aware that education and service provision, whilst separate, carry implications for each other. It would seem that the Approval Exercise has brought about improvements in the training of consultant psychiatrists[1] and it is hoped that this translates into better clinical practice. In addition, the CTC is aware that those centres unable to provide training of adequate range or quality may lose their trainees with repercussions for the provision of service.

The CTC believes that changes in style in the provision of psychiatric services are inevitable if psychiatry is to achieve both an improved consultant: population ratio and a realistic career structure. The Approval Exercise works and should continue. The problems of service provision have not been addressed and the CTC believes are more appropriately the subject for further debate within the College.

JULIE HOLLYMAN
Chairman

Collegiate Trainees Committee

REFERENCE

[1]BROOK, P. (1980) Is psychiatric training improving? *British Medical Journal*, **281**, 787–88.

DEAR SIRS.

Professor Rawnsley (*Bulletin*, July 1984, **8**, 139), in reply to my letter (*Bulletin*, April 1984, **8**, 74–75), feels that the Approval Exercise is an 'excellent aperient' which is 'constructively productive'. He pays tribute to the Conveners, visiting members and Dean who carry this heavy burden.

My point was that the Approval Exercise (aperient or otherwise) is being dispensed without any clinical trials to prove its efficacy, and with no consent from the 'patients'. I wonder what the Committee on the Safety and Medicines and the Mental Health Act Commission would make of that!

Furthermore, although I am sure that the dispensers are industrious and loyal, it would seem that the product is not only of uncertain value, but it could have serious (if not irreversible) side-effects, especially in the North West.

Perhaps Professor Rawnsley should visit our region, the pioneers of DGH psychiatry, and see our side-effects for himself.

MICHAEL LAUNER

Burnley General Hospital,
Burnley, Lancs.

(This correspondence is now closed—Eds.)

Mental Health Review Tribunals

DEAR SIRS

We write with reference to the article, 'Tribunal Nouveau 1983: A First Taste of the Mental Health Act' (*Bulletin*, February 1984, **8**, 23–24), written by one of us (AF) concerning the case of a psychotic woman who won her appeal against detention under Section 2 of the 1983 Mental Health Act. We thought our colleagues may wish to know the outcome of the case. The patient was found dead in her home on 29 February 1984. The subsequent coroner's report recorded the cause of death as 'myocardial ischaemia'. Although the cause of death was not psychiatrically related, the manner of her discharge from hospital made any sort of supervision—medical, psychiatric or social work—impossible.

Prior to her reception at the psychiatric unit under Section 2 she had been admitted to the medical wards for treatment of congestive cardiac failure. Arguably, her refusal to accept medication, even that prescribed for her heart condition, could have been due to her psychiatric illness. Adequate assessment followed by treatment for her psychotic state and continued supervision in the community might have prevented her death.

Dr Reeves suggests (*Bulletin*, May 1984, **8**, 95) that we should have used Section 3 of the Act. This illustrates the dilemma described in the original article. With the benefit of hindsight, it may have been more appropriate to have applied for Section 3. At the time, however, this course of action seemed unduly Draconian, and the patient was admitted from a medical ward to the psychiatric unit for assessment, not treatment, in the first instance. Despite her well-organized, widespread delusional beliefs and the previous history of self-neglect, our patient had an intact personality and was extremely vocal and verbally articulate in her complaints. She was certainly able to persuade the Mental Health Tribunal that the Section 2 should be discharged. She had never received psychiatric treatment and the clinical team were optimistic that a short duration compulsory order would be sufficient, with the option to apply

for Section 3 should this be necessary.

Unfortunately, this course of action was not available to us and our patient died, her rights to remain untreated uninfringed.

ANNE FARMER

Institute of Psychiatry
London SE5

JEREMY BOLTON

St George's & Springfield Hospitals
London SW17

Future of the consultant in psychiatry

DEAR SIRS

In his article (*Bulletin*, July 1984, **8**, 122–23) Professor K. Rawnsley expressed the need for the re-appraisal of the role to be played by consultant psychiatrists in the future. This is an excellent, progressive idea which will abolish the present isolation and sectorization of the different branches of psychiatric practice.

Professor Rawnsley advocated that child and adolescent psychiatry be kept separate from other specialties, possibly in an attempt to avoid labelling children as 'psychiatric' cases. These specialists should work with paediatricians in order to avoid this problem.

So far as adults are concerned, psychiatrists are to declare their special interest in some sub-specialty. I would suggest two main sub-specialties as follows:

Organic psychiatry: incorporating the psychiatry of mental handicap; the psychiatry of old age; and organic brain diseases such as epilepsy, dementia, genetic disorders, etc.

Functional psychiatry: incorporating neurosis; personality disorders; depressive illness; psychosis; alcoholism and drug dependence; psychosexual disorders; and forensic psychiatry, etc.

The two types of psychiatrist will work from the same base hospital and will have opportunities to develop research interests, all necessary facilities being available to them. Working in close liaison, they will be able to provide a high standard of psychiatric care for their patients.

I hope that the College will take note of this suggestion and negotiate with the DHSS in order to implement reorganization in the near future.

U. J. DEY

Brockhall Hospital
Blackburn, Lancs

Registrars' training in mental handicap

DEAR SIRS

It is encouraging to see that the College has been very particular about the requirement of mental handicap training for registrars in the rotational training schemes. However, it is important for the College Assessors to note that the training should not become so inflexible and structured that the service part of it is disregarded. This seems to be happening to a greater or lesser extent to many training programmes, resulting in certain deficiencies in training, and, equally importantly, adversely affecting the quality of care and treatment of patients. I consider, and many of my consultant colleagues may agree, that in-service training is a vital part of any registrars' training programme. Today's trainees are tomorrow's potential consultants, and must learn a balanced and practical view of the work in this field. This is particularly relevant to the mental handicap field, as this has been a deprived and deficient specialty and most of the consultants in this field are overworked and under great stress and would find the added burden of training difficult to cope with if not linked with in-service training.

The College has done a great service by recognizing the clinical and training needs of this specialty as part of overall psychiatric training, and I am sure would be perceptive enough to demand from the trainees equal effort and input in the in-service aspects of the training, which includes a major share of clinical work with patients. Otherwise too much structuring and 'spoon feeding' may result in a not so well equipped trainee at the completion of the training requirement. I am expressing this concern both as a participant and observer in the registrar's training programme.

T. HARI SINGH

Morgannwg Health Unit
Hensol Hospital
Pontyclun, Mid Glamorgan

'Clomipramine Challenge Test'

DEAR SIRS

Following Dr A. G. W. Holmshaw's letter (*Bulletin*, April 1984, **8**, 76), I would like to report a patient who developed psychotic symptoms three weeks after Clomipramine administration for her depressive illness.

A 28-year-old unmarried secretary was admitted with a three-month history of depression with suicidal intent, following her job change. She was started on Clomipramine 75 mg nocte which was increased to 150 mg nocte after a week.

Pre-morbidly she used to be a shy, withdrawn person who was not a good mixer. Three weeks following her admission when she went home on weekend leave after a slight improvement she started to behave very strangely. She became mute and started shaking her head, arms and legs. She then talked about an imaginary boyfriend. She giggled inappropriately and believed she could hear her own thoughts. Clomipramine was stopped. She still remains odd; smiling inappropriately (almost continuously) and shows emotional blunting.

J. NADARAJAH

Cane Hill Hospital
Coulsdon, Surrey