



58 of the Mental Health Act 1983, among others for clozapine. He was experiencing hypersalivation as a side-effect so was prescribed hyoscine hydrobromide. It was not thought necessary to include this on the Form 38 as hyoscine is not a psychotropic drug. The Commissioner, however, stated that the hyoscine was not authorised, meaning the medication had been unlawfully administered, and the Avon and Wiltshire Mental Health Partnership NHS Trust had to advise the patient about his right to seek legal advice.

Hyoscine appears twice in the British National Formulary, in the chapter on the central nervous system under 'Drugs used in nausea and vertigo' and in the chapter on anaesthesia under 'Antimuscarinic drugs'. Hyoscine is not classified under 'Antimuscarinic drugs used in parkinsonism'. Antimuscarinic drugs used for anaesthesia is quite distinct from 'Antimuscarinic drugs used in parkinsonism'. We do regard the latter as needing to be documented on the legal paperwork, such as precyclidine, because of an accepted recognition of good practice. Is it now the case that for any side-effect caused by psychotropic medication that is being treated by drugs, these drugs need to be listed on Forms 38/39? If so, should our patient's senna and metformin be listed as well, as the constipation and diabetes he has is likely (but of course not necessarily) to be a result of the clozapine?

BMJ PUBLISHING GROUP & RPS PUBLISHING (2007) *British National Formulary* 54. BMJ Publishing Group & RPS Publishing.

**\*Vichal Woochit** Specialty Registrar year 4, Wickham Unit, Blackberry Hill, Bristol BS16 1ED, email: vichal.woochit@awp.nhs.uk,  
**Syed Husain** Consultant Forensic Psychiatrist, Wickham Unit, Blackberry Hill, Bristol

doi: 10.1192/pb.32.5.196b

## New exam structure – too much too soon?

The last examinations in the 'old format' have now finished, making the editorial and commentaries on 'The long case is dead' very timely (Ashurst, 2007; Benning & Broadhurst, 2007; Tyrer, 2007). In addition, psychiatric training is undergoing significant change, particularly following the difficulties associated with Medical Training Application System, and Modernising Medical Careers.

With the move towards competency-based curricula, it is important to reassess the way that trainees are assessed. Objective Structured Clinical Examinations (OSCEs) are increasingly used to assess medical students instead of the traditional long and short cases. Long cases have been used in examinations since the 1970s

and while standardisation of OSCEs is easier, each station provides only a snapshot of a candidate's performance.

Workplace-based assessments are a useful addition in the assessment of trainees' competences and will now be the main method of evaluating their ability to perform a full comprehensive clinical assessment. However, these are new tools for both trainees and supervisors and it will take time and further development before they become a reliable method of assessment.

Many trainees have prepared for one examination format only to be forced into a new system, while the transitional arrangements mean that some aspects of the curriculum will not be tested in those who have obtained Part 1 and are exempt from Paper 2. Neither of these situations is ideal. An overlap between the old and new examination formats may have allowed an easier transition to a new way of working for trainees and help avoid the significant anxiety experienced by those affected by the changes.

ASHURST, P. (2007) On listening to the patient: Commentary on... The long case is dead. *Psychiatric Bulletin*, **31**, 446–447.

BENNING, T. & BROADHURST, M. (2007) The long case is dead – long live the long case. Loss of the MRCPsych long case and holism in psychiatry. *Psychiatric Bulletin*, **31**, 441–443.

TYRER, S. (2007) Non mors praematura: Commentary on... The long case is dead. *Psychiatric Bulletin*, **31**, 447–449.

**Elena Baker-Glenn** Specialist Trainee Year 3, Queen's Medical Centre, Nottingham NG7 2UH, email: elenabakerglenn@yahoo.co.uk

doi: 10.1192/pb.32.5.197

## Forensic psychiatry and general psychiatry: re-examining the relationship

I have heard the essence of the Turner & Salter article (*Psychiatric Bulletin*, January 2008, **32**, 2–6) before but repetition does not produce enlightenment. At root, it is an attack on a branch of medicine that the authors do not seem to approve of. That is odd: I cannot think of any other branch of medicine which attracts this kind of negativity.

As John O'Grady has explained in his reply (*Psychiatric Bulletin*, January 2008, **32**, 6–7), there are many reasons why forensic psychiatry has developed. Nevertheless, one omission from the debate so far, which is surprising in view of one of Turner's other strong interests, is history. It is easy to trace the development of forensic psychiatry from about 1814 as a response to a growing awareness of the social and psychiatric problems presented by many offenders with mental disorders.

The growing specialty of psychiatry was expected to take on this important group of patients. From the earliest years of this period, until the present day, general psychiatrists have tried to resist this expectation. Personally, I think that is entirely reasonable, as such patients require special facilities and special skills. However, it is unreasonable to complain when others take up the challenge instead.

For many years there were very few who took an interest in this work and very few facilities for such patients. As pressure from general psychiatrists, prisons and mental hospitals (which gradually declined in number) increased, so did the demand for special skills. With that, overcrowding in the first forensic psychiatry hospitals, the special hospitals, also increased.

The natural professional response to this was for psychiatrists, with the unusual special interest in offenders with mental disorders, to get together to discuss matters, especially clinical matters, of mutual interest. A forensic psychiatry subcommittee of the Royal Medico-Psychological Association (the forerunner to the Royal College of Psychiatrists) was formed in 1963. This became a section of forensic psychiatry when the Royal College of Psychiatrists began in 1971, and eventually, in 1997, the Faculty of Forensic Psychiatry. The clinical meetings of this developing organisation have attracted an increasing number of College members. Any psychiatrist is welcome to attend the meetings and general psychiatrists, as Turner and Salter know well, are especially welcome. We even invite them to express their negative views in debate!

Perhaps there is a hidden agenda to all this. Speculation is usually unhelpful, so I will not indulge. Maybe I can, however, entice Trevor Turner to spell out more closely what ails him. Does he have the same allergy to other specialties, and if not, then why not? I think I can speak for the majority of members of the Forensic Psychiatry faculty when I say that they are always interested to learn new ways of working and to serve patients' interests better.

**John Gunn** Former Chairman, Faculty of Forensic Psychiatry, and Emeritus Professor of Forensic Psychiatry, Institute of Psychiatry, King's College London

doi: 10.1192/pb.32.5.197a

## Trainees' views on service user and carer involvement in training: a perspective from the West Midlands

A survey similar to Babu *et al* (*Psychiatric Bulletin*, January 2008, **32**, 28–31) was