the columns

correspondence

Should liaison psychiatry change its name?

In recent negotiations local healthcare commissioners told us that we would be unlikely to attract additional resources to our liaison psychiatry service until we changed our name because 'We don't know what you do!'. A suggested alternative is psychological medicine.

We asked 48 patients referred to our service and 108 general hospital staff for their preferred name for our service from a choice of four: psychological medicine, medical psychiatry, liaison psychiatry, hospital psychiatry. The preferences of the two groups were significantly different (χ^2=22.7, P<0.001). The first choice of patients was psychological medicine (44%), with 27% preferring liaison psychiatry. The first choice of hospital staff was liaison psychiatry (42%), with only 16% preferring psychological medicine. A number of patients commented that the word 'liaison' was not well understood and 'psychiatry' was off-putting and intimidating. Hospital staff, however, commented that they were familiar with our service and that a change of name would be confusing.

We have decided to continue as 'liaison psychiatry' because we are well established and our service is understood by our referrers. However, we recommend that a newly established service consider psychological medicine as a name that is preferred by many patients, and one that may be perceived as less stigmatising.

One group that we have not surveyed is our commissioners. However, it is clear that without an alternative name we will have to educate them about the benefits of liaison psychiatry.

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Statutory role of the duty consultant

Dr Husain (*Psychiatric Bulletin*, August 2005, **29**, 316) makes a very pertinent point in response to my proposal that duty consultants be replaced by telephone advice. Some jurisdictions (most notably England and Wales) may require a face-to-face interview with a senior psychiatrist before a person can be detained. However, the question remains whether or not such interviews contribute anything which could not have been achieved by other means. By making ourselves available 24 h a day, are we not, as a profession, effectively saying that we believe this to be clinically necessary? Legislators have responded to this perceived necessity but in doing so have paradoxically created the potential for the scenario described by Dr Husain, of urgent patient care being delayed. We have created a statutory demand for our services which is based on traditional working practices (prior to the revolutionary changes in telecommunications and mental health nursing), rather than on a rational appraisal of how best to utilise scarce resources and optimise patient care.

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Junior doctors' strange love of information technology

Dr Holloway (*Psychiatric Bulletin*, July 2005, **29**, 241–243) suggests that the education of the current generation of psychiatric trainees has emphasised information technology skills which psychiatrists of an older generation may be reluctant to embrace. A survey of 75 mental health doctors in Lincolnshire with a response rate of 64% (n=48, 38 males, 10 females, mean age=41 years, s.d.=10) confirmed that the overall knowledge of information technology was better among senior house officers (SHOs) and specialist registrars (SpRs) (n=18, 37.5%) than consultants and staff grade doctors (n=30, 62.5%). For example, 17 out of 18 SHOs and SpRs (94%) rated their knowledge of PowerPoint as good to excellent compared with 13 out of 30 consultants and staff grade doctors (43%; P<0.001). Significant statistical differences were found between the two groups in the use of Excel (61 *v.* 29%, P=0.05) and searching medical databases (89 *v.* 60%, P=0.049). However, there were no statistically significant differences between the two groups in the use of Word (94 *v.* 76%) and Outlook Express (72 *v.* 67%). Use of the Statistical Package for the Social Sciences was limited in both groups (33 *v.* 20%). Consultants and staff grades did, however, use the trust's electronic patient information system more frequently than junior doctors (43 *v.* 17%). Perhaps the eventual introduction of electronic care records will lead any remaining reluctant psychiatrists into the information age.

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Changes in psychiatric education

I have read with interest recent publications regarding the proposed changes in psychiatric education (Brown *et al*, *Psychiatric Bulletin*, June 2005, **29**, 228–230; Royal College of Psychiatrists, 2005) and have wondered where psychotherapy training, as part of basic specialist training, will fit in. Currently, the recommended requirements (Royal College of Psychiatrists, 2003) are very difficult to achieve. Senior house officer (SHO) rotations have expanded in recent years and there are limited resources in many psychotherapy departments, especially for psychodynamic psychotherapy; therefore finding appropriate patients and supervisors is a problem.

In Nottingham, all SHOs attend an introductory course in psychotherapy, most have the opportunity to join a case discussion group and great steps are being taken to improve access to cases. It is hoped that consultant psychiatrists and other mental health professionals, with adequate training and supervision,

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