the columns

correspondence

Sir: Harrington et al (2002), in their description of a one-day national survey of prescribing, speculate that poor documentation of the decision to prescribe high-dose antipsychotic regimes may be due to sub-optimal record keeping, lack of awareness that the regime was high-dose or both. We have recently completed an audit cycle, which sheds light on this issue in our unit.

We audited antipsychotic prescribing in Fromeside Regional Secure Clinic for the whole of 2000 and again in the latter 6 months of 2001 (43 patients), against standards based on the Royal College Consensus statement (Royal College of Psychiatrists, 1993). The patients were male forensic detainees, all factors associated with the prescription of high dose regimes (Lelliott *et al*, 2002).

Our audit showed rates of high-dose prescribing of 19% and of polypharmacy of 35% in the first period, and 31% and 46% respectively in the second period. In the first period, a clear statement of indication and decision to prescribe a high-dose regime was included in only 25%, and an ECG had been performed in 0%. In the second, these standards were met in 0% and 25% of cases. Results of our first survey were presented to the teams involved and the standards circulated. It is therefore our suspicion that these poor results were due to a lack of routine prescription monitoring. We are incorporating monitoring procedures into prescription charts and case conference paperwork. Prescribing is a core medical responsibility; our patients deserve careful attention to detail.

HARRINGTON, M., LELLIOTT, P., PATON, C., *et al* (2002) The results of a multi-centre audit of the prescribing of antipsychotic drugs for in-patients in the UK. *Psychiatric Bulletin*, **26**, 414–28.

LELLIOTT, P., PATON, C., HARRINGTON, M. *et al* (2002) The influence of patient variables on polypharmacy and combined high dose of antipsychotic drugs prescribed for in-patients. *Psychiatric Bulletin*, **26**, 411–14.

ROYAL COLLEGE OF PSYCHIATRISTS (1993) *Consensus Statement on the use of High Dose Antipsychotic Medication*. Council Report CR26. London: Royal College of Psychiatrists.

Syed Husain, Adrian Feeney Specialist Registrars, **Arden Tomison** Consultant, Fromeside Clinic, Blackberry Hill, Bristol BS16 1ED

Gay and lesbian partners of mentally ill patients

Sir: It is pleasing to note that one discriminatory aspect of law reported by the College's Gay and Lesbian Special Interest Group (Bartlett *et al*, 2002) was recently overturned in the courts.

In *R on the application of SSG and Liverpool City Council and Secretary of State for Health* (CO/1220/2002, finalised on the 7 November, 2002), the court declared that the homosexual partner of a patient can be treated as falling within the phrase 'living with the patient as the patient's husband or wife as the case may be' in s26(6) of the Mental Health Act 1983.

This means that it is now possible to construe same-gender partners as equivalent, both in meaning and in effect, to 'husband or wife' at s26(1) of the Act. Same-sex partners so construed can, therefore, now be recognised as having priority when determining the identity of a patient's nearest relative.

BARTLETT, A., WARNER, J. & KING, M. (2002) Gay and Lesbian Special Interest Group: nearest relatives of gay men and lesbians. *Psychiatric Bulletin*, **26**, 437–438.

Mat Kinton Policy Advisor and Communications Manager, Mental Health Act Commission, Maid Marian House, 56 Hounds Gate, Nottingham NG1 6BG

Altruistic suicide: precedence in usage

Sir: Dr Spencer's correspondence 'The Suicide Bomber – Is it a psychiatric phenomenon?' (*Psychiatric Bulletin*, November 2002, **26**, 346) perpetuates the belief that Durkheim was the first to use the term altruistic suicide. Altruistic suicide was described by George Savage as 'To save others from suffering. To benefit others', in his chapter on suicide and insanity in Tuke's *Dictionary of Psychological Medicine* in 1892. Furthermore, the notion of suicide as self sacrifice was also described by Mercier in his book *Sanity and Insanity* in 1890.

Whilst the concept of altruistic suicide is usually attributed to Durkheim, the evidence is persuasive that Savage deserves scientific precedence in the use of this term. This has been discussed further in *Pre-Durkheim Suicidology: The 1892 Reviews of Tuke and Savage* (Goldney and Schioldann, 2002).

GOLDNEY, R. D., SCHIOLDANN, J. A. (2002) *Pre-Durkheim Suicidology: The 1892 Reviews of Tuke and Savage*. Adelaide, Adelaide Academic Press.

MERCIER, C. (1890) *Sanity and Insanity*. London, Walter Scott.

TUKE, D. H. (1892) *A Dictionary of Psychological Medicine*. London, J. & A. Churchill.

Robert D. Goldney, FRCPsych The Adelaide Clinic, 33 Park Terrace, Gilberton, South Australia, Australia 5081

On compassion for the SHOs

Sir: I run a weekly group for senior house officers (SHOs) in psychiatry to help them make sense of their clinical experiences in general psychiatry and develop a depth of sensitivity with their patients. A patient was presented with the problem that no one in the team felt any compassion for her and her behaviour, and this clearly affected any notion of therapeutic progress. The staff needed help to become understanding of the difficulties from the patient's angle.

Preceding the seminar, I was talking with the SHO's about the anxiety that dominates all their minds, namely the MRCPsych examination. One was left with the question, what example is the College giving the SHO's in relation to sensitivity and compassion for their ordeal?

If the SHO's pass their multiple choice, they are then sent anywhere throughout the UK and Eire for the clinical. This clearly is an antiquated system in need of revision. There is no reason for not holding the clinicals within defined local areas e.g. London, South East England, The Midlands, Scotland, Wales, Ireland etc. At present our SHO's are being sent unnecessarily all over the place for their clinicals, for example from London to Bangor, Paisley, Aberdeen and Dublin and vice versa. They are already in a very stressed state, waiting to do their clinicals. They are then made to travel great distances to far-flung places, which may

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even operate under an unfamiliar Mental Health Act.

In many cases, the travel and hotel expenses are considerable for the SHO's to pay. If they do eventually pass the exam, the letter of congratulations asks straight away for the membership fee. It leaves an impression that all the College is interested in is money, and is lacking in human compassion and thought for their SHO's.

The SHO's do not seem to have an effective voice in the College. In general psychiatry, we now have effective users' groups representing the patients. We need a similar effective voice representing the SHO's. My SHO's said that they would be most grateful if I would write to the College on their behalf.

If the College is experienced by the trainees as insensitive to their feelings, this should be a matter of general concern for the membership. I wonder if there are others in the College, whether affiliates, or members who also feel that there is a need to alter the MRCPsych exam arrangements with more thought and compassion for the SHO's position?

Richard Lucas Consultant Psychiatrist, St Ann's Hospital, 63 Ossulton Way, London N2 0JY

Points in response to letter from Dr Lucas

In allocating candidates to clinical centres, the criteria are that they are not sent to a centre where they have previously worked, where they are currently working or where they have been examined before.

The College is dependent upon the centres which volunteer their resources to accommodating the clinical examinations and although, geographically, these are spread as widely as possible it inevitably can mean that candidates are required to travel to a centre that meets the allocation criteria. Candidates are made aware of this when entering for the examination.

These criteria were put in place and continue to be operated in the best interests of the candidates. In implementing them, the aim is to ensure that all candidates have an equal chance in the assessment, and that no one could construe that they have been either advantaged or disadvantaged by having had previous contact with the patients with whom they will be presented during the clinical examination.

Every effort is made to allow candidates sufficient time to make their travel plans to the clinical centre to which they have been allocated. The minimum time which candidates will have to arrange their travel and, if necessary, accommodation is 2 weeks.

Professor O. A. Oyebode Chief Examiner

I agree entirely with Dr Lucas that SHOs need and deserve an effective voice within our College. We have two mechanisms in place to achieve this. The Inceptorship scheme is open to all trainees intending to take the MRCPsych examination and puts them in contact with the College, provides them with free or subsidised subscription to the College Journals and gives them regular information about relevant College events. In addition, SHOs form an important part of the Collegiate Trainee Committee (TC) membership. Through the CTC, SHOs (as well as specialist registrars) are represented on all key College committees.

Professor Cornelius Katona Dean

the college

Winter Business Meeting

4.30 pm on 24 January 2003, to be held at the Royal College of Psychiatrists following the meeting of Council. Chaired by the President, Dr Mike Shooter.

Agenda

(1) To approve the Minutes of the previous Winter Business Meeting held at the Royal College of Psychiatrists on 5 February 2002
(2) Obituary
(3) Election of Honorary Fellows

John Bowis OBE MEP

Mr Bowis is a dedicated career politician, who has consistently demonstrated commitment to mental health issues, firstly as a Member of Parliament committed to constituency issues, secondly as a government Minister for Health when he held the mental health portfolio for 3 years, thirdly as a full-time consultant to the World Health Organization (WHO) Collaborating Centre at the Institute of Psychiatry and now as a Member of the European Parliament. He gives his time freely to the mental health cause, within the European Parliament, within the UK and across the world. He has been an active contributor to a number of College conferences and events. Some examples of mental health initiatives during his time as Minister for Health include: the Homeless Mentally Ill Initiative, which set up outreach teams and hostels, and the inquiry into mental health of Black people in the UK. Mr Bowis launched the Spectrum of Care, conferences of users and purchasers in 24-hour nursed care; the medium secure beds expansion of the Glancy Report; and the suicide prevention strategy, and departmental support of the Defeat Depression Campaign. He has raised the profile of child and adolescent mental health and secured significant increases in funding for mental health services; he reviewed the future of high-security hospitals and the care of people with personality disorder and took a number of initiatives to improve the care of people with learning disabilities. While supporting the WHO global campaigns on mental health and on epilepsy, he opened doors to Health Ministers in various parts of the world and helped mental health professionals influence the health priorities of their governments. John Bowis is a great ally for mental health, who has played a substantial role in stimulating international and national political will to improve mental health services throughout the world.

Lord Melvyn Bragg

The work of Lord Melvyn Bragg, FRSL, DLitt, MA, FRTS, television presenter, novelist and broadcaster, and currently President of MIND, will be very familiar to most people. Lord Bragg's name is synonymous with the arts in general. He has worked in broadcasting since 1961 and is currently Controller of Arts and Features at London Weekend Television (LWT), Editor and Presenter of *The South Bank Show* and Executive Producer of several other arts' strands. He also writes for numerous publications. He is President of the National Campaign for the Arts, a Governor of the London School of Economics and Political Science and Chancellor of Leeds University. He was made a Life Peer in 1998. In 2001, he won the Prix Italia Special Award for 25 seasons of *The South Bank Show* and, among many other achievements, has received Honorary Doctorates and Fellowships from numerous academic organisations.

Lord Bragg has been involved with MIND in Carlisle for 16 years and became President of the national organisation in 2001. His awareness of the distress experienced by those with mental illness and of the stigma surrounding mental health has strengthened his resolve to campaign on mental health issues in the House of Lords and to raise awareness of the extent of the problem.

Professor John Cox

Professor John Cox can be justifiably singled out as an individual whose contribution has been exceptionally distinguished across various medical disciplines. His activities have been extremely wide-ranging over a very long period covering

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