



# the columns

## correspondence

### Patient or client?

Sir: We were interested to read Ritchie *et al*s (*Psychiatric Bulletin*, December 2000, **24**, 447–450) findings on what individuals in contact with psychiatric services wish to be called and we would like to add our own preliminary results from our ongoing project, which support their findings.

Out of 137 consecutive attenders at a general adult psychiatry clinic, 114 (83%) preferred to be described as a 'patient', 18 (13%) preferred to be described as a 'client' and the remainder express no preference, or preferred other terms.

These results provide further evidence to support the use of the traditional term 'patient' rather than politically correct alternatives. The Orwellian use of language may damage the speciality of psychiatry by marginalising it in the field of medicine and contributing to the stigma of mental illness. The majority of individuals who visit psychiatrists subjectively describe suffering (*patire*). Many individuals visiting cardiologists do not describe subjective suffering – they have no symptoms. Cardiologists are unlikely to address their patients as client – why should psychiatrists?

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### The Government's proposals to reform the Mental Health Act

Sir: The proposals to reform the Mental Health Act can only lead to a massive increase in the number of individuals compulsorily detained. It is difficult to underestimate the impact that the ludicrously broad definition of mental disorder (without the exclusions in the 1983 Act); the replacement of the 'treatability' clause with a requirement that treatment need only control the behavioural manifestations of the disorder; and the low threshold for compulsion (a 'significant risk') (Department of Health, 2000) will have upon already overstretched services. Psychiatric services will find their beds filled by anybody deemed to be a risk to the public

who can be squeezed into an ICD–10 or DSM–IV diagnosis; that is, pretty much the entire prison population and many others besides.

There is a fine line between a relatively minor offence and an offence "from which the victim would find it hard to recover" (Department of Health, 2000), such as section 18 on wounding. Those who routinely deal with offenders are aware that the outcome often has more to do with chance and degree of intoxication than any easily distinguishable psychopathological features.

Although there has always been debate within the profession regarding the management of personality disorders, it is generally accepted that psychological treatments cannot be delivered without the motivation and cooperation of the patient. The Government propose to replace the 'lottery' of treatability with the certainty of 'preventative detention', regardless of the impact this is likely to have on services and patients. All this because of an unsafe conviction.

Anybody for another Fallon Inquiry?

DEPARTMENT OF HEALTH (2000) *Reforming the Mental Health Act. Part II. High Risk Patients. CM 5016-II*. London: Stationery Office. (2000)

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### Evidence-based journal clubs and the Critical Review Paper

Sir: Dhar and O'Brien (*Psychiatric Bulletin*, February 2001, **25**, 67–68) present a trainees'-eye view of the Critical Review Paper of the Membership examination. They advise setting up evidence-based journal clubs (EJBC) to teach critical appraisal skills, but what is an EJBC?

The practice of evidence-based medicine (EBM) involves conscientious, explicit and judicious use of current best evidence in making decisions about individual patients' care (Sackett *et al*, 1996). This requires formal assessment of the quality and implications of available evidence to maximise the quality of clinical decision-making. It is unlikely that an EJBC can truly emulate EBM without considerable work (Walker *et al*, 1998). How then do trainees prepare for the Critical Review Paper?

In Inverclyde, we hold a weekly journal club attended by all grades of medical staff, which alternates between an EBJC and a 'critical appraisal journal club' (CAJC) format. In EBJCs, presenters address a clinical question with reference to the wider literature. Summaries of relevant papers lead to an overall awareness of the current evidence base and a 'clinical bottom line' is established. The CAJC aims to teach the skills examined in the Critical Review Paper. A single article is chosen and introduced with reference to critical questions such as those proposed by Greenhalgh (1997). The audience participates in the appraisal process. The strengths and limitations of the research inform result interpretation, and the participants derive conclusions on that basis.

Trainees find the CAJC format beneficial in their preparation for the Membership examination. We commend this format to training schemes throughout the British Isles.

GREENHALGH, T. (1997) *How to Read a Paper, Basics of Evidence-Based Medicine*. London: BMJ Publishing Group.

SACKETT, D. L., ROSENBERG, W. M. C., GRAY, J. A. M. *et al* (1996) Evidence based medicine, what it is and what it isn't. *British Medical Journal*, **312**, 71–72.

WALKER, N. P., McCONVILLE, P. & DEWAR, I. G. (1998) The practice of evidence-based journal clubs. *Psychiatric Bulletin*, **22**, 640–641.

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### Who can best protect patients' rights?

Sir: I would like to correct two inaccuracies in your editorial comment on my paper that was published in the October 2000 issue of the *Bulletin* (pp. 366–367).

First, you state that no central authority keeps statistics on managers' hearings and that discharges by managers "are now unheard of [at least until Gregory's report from Kingston]".

The Mental Health Act Commission (MHAC) keeps statistics on managers' hearings. The relevant information is contained in the commission's analysis of hospital profile sheets for 1998/99. I