columns

As both issues tend to be problematic for even the most experienced and battle-hardened researcher is this a reflection of the sort of studies being conducted? Of course, to participate in larger studies would include the attendant risk of delayed or indeed no publication!

Declaration of interest

A.M.H. and M.G. both undertook full-time research placements as higher trainees.

HULL, A. M., GUTHRIE, M. (2000) Full time research placement as a higher trainee. *BMJ*, **320**, s2–7249.

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Mental health review tribunals and legal representation – equality of arms?

Due to the influence of the European Convention on Human Rights and Fundamental Freedoms and the enactment of the Human Rights Act 1998, quite properly, virtually all patients are legally represented in Mental Health Review Tribunals. Indeed, the European Court of Human Rights has decided that in certain circumstances patients' rights may be breached if they are not represented in proceedings, even when, in fact, they have not requested a lawyer (Megyeri *v.* Germany, 1992). However, it is important to note that both sides of tribunal proceedings are not treated equally.

One of the basic tenets of justice is the concept of equality of arms, i.e. 'a reasonable opportunity of presenting the case to the court under conditions which do not place him in substantial disadvantages vis-à-vis his opponent' (Kaufman *v.* Belgium, 1986). The expression of this in regard to tribunals is enshrined in Article 5(4), (everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of this detention shall be decided speedily by a court and his release ordered if the detention is not lawful). It is the interpretation of this Article which has led patients to receive free legal representation in tribunals. What is anomalous, and indeed perverse, is that in England and Wales the detaining authority has no such legal representation and almost entirely relies on the Responsible Medical Officer to argue the case for continuing detention. It is theoretically possible for the Responsible Medical Officer to legally represent the detaining authority (R. on the application of Mersey Care Trust *v.* MHRT [2003]) but this could clearly never be to the same skill level as a trained solicitor or, indeed in certain circumstances, a barrister and rarely happens in practice. In an increasingly litigious and complex world, it not only appears amateurish and one-sided but, more significantly, the appropriate balance of the States' obligations and the patients' rights cannot be fairly struck, which cannot be in the best interests of either the patient or of society. In contrast, in Northern Ireland however, where the relevant legislation is largely based on the Mental Health Act 1983 (Mental Health (Northern Ireland) Order 1986), nearly all Mental Health Review Tribunals have legal representation for both the patient and the detaining Trust. From personal experience, this allows a fuller, more considered, and indeed expert, appraisal of the evidence. If this is good enough for one part of the United Kingdom, why not for another part and could this in itself be seen as discriminatory and thus, in itself, contrary to the Human Rights Act? Lack of resources are often cited as the reason for the Trust not to be legally represented but should certainly not be at issue here and the courts have already declared, in relation to tribunal delays, that the state has an obligation to fund important human rights issues irrespective of cost (R. *v.* MHRT and Secretary of State for Health, ex parte KB and others [2003]).

I suggest that this fundamental imbalance has been overlooked as an issue for far too long and is worthy of further debate and, hopefully, rectification.

Declaration of interest

I am a medical member of the Mental Health Review Tribunal.

KAUFMAN V. BELGIUM (1986) 50 D.R.98.

MEGYERI V. GERMANY (1992) Series A, No. 237-A; 15 E.H.R.R. 584.

R. ON THE APPLICATION OF MERSEY CARE TRUST V. MHRT (2003) EWHC 1182 (Admin).

R.V. MHRT AND SECRETARY OF STATE FOR HEALTH, EX PARTE KB AND OTHERS (2003) EWHC 193 (Admin).

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Training within the European Working Time Directive

Now that 1 August has passed, all trusts should have implemented the hours and rest requirements stipulated in the European Working Time Directive (EWTD). This has been a challenge, and solutions have had to be creative; in psychiatry, many Trusts are attempting to reduce senior house officers (SHOs)' night commitments, rather than implementing a shift system akin to other specialties.

In order to reduce the night workload, responsibility for assessing and managing patients in accident and emergency (A&E) departments has shifted from the SHO, and is now more frequently done by nurse-led emergency teams. While a multidisciplinary approach is to be applauded, too often the SHO is not part of the process for fear of contravening the EWTD.

Assessing patients in A&E when on-call is invaluable for developing many of the skills that make a good psychiatrist, particularly risk assessment. Patients are seen when acutely unwell and sometimes it will be their first presentation. The patients in A&E often represent the more complex cases, with social problems and substance misuse as well as mental illness. Practice in dealing with these patients is crucial to developing psychiatric skills during the training period.

I feel if SHOs' exposure to patients in A&E is reduced in the name of EWTD compliance, training will suffer. To echo Sir William Osler, to train without reading books is to go to sea without any charts, to train without seeing patients is to not go to sea at all. I think that psychiatric trainees are in danger of missing the boat.

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Copying letters to patients

Sarah Hulin-Dickens (*Psychiatric Bulletin* (Correspondence) August 2004, **28**, 305) expresses considerable concern about the issue of copying letters to patients.

In contrast, my experience over 15 years of this practice is very positive. Parents are extraordinarily grateful and the patients themselves have no hesitation in correcting any errors and pointing out any omissions. The letters form a useful forum for further discussion, as well as a reminder of previous discussions. On no occasion have I ever received a complaint, either from a patient, a parent or any of the many professionals who receive copies of such letters.

This experience is shared by a number of colleagues and I hope that Dr Hulin-Dickens will feel reassured.

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Pharmacogenetics and addiction services

I support the view of Hodgson *et al* (*Psychiatric Bulletin*, August 2004, **28**,

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columns

298–300) that future developments in genetics may lead to tailored treatments for psychiatric patients. Currently in addiction services, these technologies are not yet generally in use. However, recent developments suggest they may soon be available to patients.

Like antipsychotic drugs, nicotine is metabolised by a cytochrome enzyme complex (CYP 2A6). In past years, much attention has focused on the effect of functional variants of the CYP 2A6 gene on smoking status (Pianezza *et al*, 1998). More recent studies have also highlighted the potential of applying pharmacogenetics in clinical addiction services; women receiving nicotine replacement therapy (NRT) possessing a variant of dopamine receptor 2 gene (DRD2) were shown to have significantly different success rates with NRT depending on their DRD2 genotype (Yudkin *et al*, 2004).

This and other findings (Lerman *et al*, 2002) raise the issue of screening smokers with the intention of informing them which treatments they are most likely to benefit from. With rapid advances in genomic information and high throughput genotype screening techniques, more relevant functional genomic information is becoming available. Hodgson *et al* correctly infer that a thorough development phase is needed before this approach can be translated into widespread clinical applications.

In addition it will be important to protect patients against possible premature exposure to private genetic screening and advisory services using preliminary genetic findings which may not be substantiated through rigorous replication studies. With the realistic possibility of commercial involvement in gene based diagnostics, patients may be exposed to marketing strategies offering tailored smoking cessation therapies, based on preliminary/incomplete study results.

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YUDKIN, P. (2004) Effectiveness of nicotine patches in relation to genotype in women versus men: randomised controlled trial. *BMJ*, **328**, 989–990.

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Why do psychiatric patients wait too long in A&E?

By December 2004, all patients must be discharged from an accident and emergency (A&E) department within 4 hours of arrival (Department of Health, 2001). We sought to identify what factors contributed to the long waiting times experienced by some patients referred to psychiatry by our local A&E department.

Over a 2-month period in 2004, we identified 23 patients who breached the 4-hour target. More than half were patients who had self-harmed. Alcohol intoxication and awaiting the results of investigations following an overdose were common reasons for a delay. In more than a fifth of cases, a prolonged psychiatric assessment was required, including one Mental Health Act 1983 assessment. In 40% of cases, there was more than an hour's delay between referral and psychiatric assessment.

A rapid response is unlikely to reduce attendance to below 4 hours in all cases. If a psychiatrist can attend within 1 hour, and their assessment takes no more than another hour, then patients should be referred within 2 hours of attendance to achieve the 4-hour target. This occurred in only one-quarter of cases reviewed.

Striving to achieve rapid throughput for patients with psychiatric as well as physical problems may not always be possible or advisable (*Psychiatric Bulletin*, December 2003, **27**, 81–82). Obtaining background information is often a crucial but time-consuming part of an assessment. Is the drive for a rapid discharge from A&E, evidence of a sway towards 'fast psychiatry' (*Psychiatric Bulletin*, July 2004, **28**, 265–266) that runs counter to good clinical care?

DEPARTMENT OF HEALTH (2001) *Reforming Emergency Care: First Steps of a New Approach*. London: Department of Health.

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