CORRESPONDENCE

Is evidence-based psychiatry a quagmire?

Evidence-based medicine in general often feels like a quagmire. Wallace (2011) addresses the perils and pitfalls of evidence-based psychiatry in particular. Going through journals such as *The Psychiatrist* and the *British Journal of Psychiatry*, a nervous reader might become bogged down in the statistical methods. Twenty years ago, *t*-tests and ANOVA were common; today, we have SPSS computer programs and all the baffling complexities of logistic regression and factor analysis (Howitt 2008).

What articles such as Wallace's attempt is a perhaps impossible task – to make the ultra-complicated welding of mathematics and medicine comprehensible.

Statistics, as much as theology, is prone to internecine debate, with different contingents disagreeing over the concepts involved. Wallace refers to both *P*-values and confidence intervals: nowadays, the former have been replaced to a large extent by the latter (Gardner 1990). Wallace's statement that the 'number needed to treat is regarded as the most useful measure of the benefit of a treatment' is open to debate. The number needed to treat is still embedded in some controversy, and many prefer to rely on the underlying absolute risk difference.

So how much is evidence-based psychiatry like hazardous quagmire? Numbers and data *per se* are not enough. The psychiatrist without emotional insight and an intuition of the heart regarding each individual patient is a bad psychiatrist. Forcing psychiatry into the mould of the computer through statistical methods is not always for the best.

Howitt D, Cramer D (2008) *Introduction to Statistics in Psychology (4th edn)*. Pearson.

Gardner MJ, Altman DG (1990) *Statistics with Confidence*. BMJ Books.

Wallace J (2011) The practice of evidence-based psychiatry today. *Advances in Psychiatric Treatment* **17**: 389–95.

Zekria Ibrahimi, psychiatric patient, Coombs Library, West London Mental Health Trust, Southall UB1 3EU, UK. Email: ibrahimizekria@googlemail.com

doi: 10.1192/apt.18.1.78

Author's reply

Ibrahimi is correct when he states that numbers and data, so much associated with evidence-based medicine, are not sufficient in dealing with the individual patient. Emotional insight, intuition and a caring attitude are also central.

The purpose of evidence-based medicine is not to replace clinical decision-making with numbers and data. Research evidence should be considered as one of many factors when making a clinical decision. Other elements to be utilised include intuition, clinical experience and, most important, the preferences of the patient. There are, of course, situations in which research evidence should be considered but then disregarded.

Sadly, medicine and psychiatry historically are littered with examples of interventions that were based on erroneous beliefs rather than evidence, many of which had less than optimal outcomes for the patient.

Currently, the push is on to make systematic reviews and research articles less of a quagmire. The emphasis is now on developing clear, readable summaries stressing conclusions and recommendations that are tailored to a specific target audience. Accessibility is becoming central. Evidence-influenced psychiatry is perhaps a better term to describe an approach that advocates consideration of research evidence as well as clinical experience and the patient's preferences in a decision-making process that is aimed at advancing the patient's best interests and their quality of care.

John Wallace, Clinical Psychologist and Consultant Psychiatrist, DPhil Reader in Evidence-Based Healthcare, Kellogg College, 62 Banbury Road, Oxford University OX2 6PN, UK. Email: john.wallace@wadh.oxon.org

doi: 10.1192/apt.18.1.78a

Physical health examination in Section 136 suites

Hampson (2011) placed little emphasis on the initial physical assessment of detained patients. Peer-group feedback for on-call Section 12 doctors involved in these assessments in the West Midlands indicates a significant shift towards the senior psychiatrist in the responsibility for basic physical health assessment. One example was an individual with a fractured skull – identified by the assessing senior psychiatrist. The role of the psychiatric trainee in the assessment process remains uncertain. As Hampson states, it seems that very few patients are transported by ambulance. This misses an early opportunity for medical screening by paramedics and diversion to acute medical or surgical units where appropriate. Thus, the senior psychiatrist may well now be the first medically trained individual to screen patients for potentially serious non-psychiatric medical conditions resulting in behavioural disturbance. Sadly, it is recognised that senior psychiatrists may not be rehearsed in acute physical assessment (Garden 2005). Also, the facilities and equipment allowing appropriate examination can often be limited.

Although it must be celebrated that reform and progress have occurred in the move away from the routine use of police custody suites in assessing mentally disordered individuals, the practical effect on physical health assessment of these individuals has been the loss of screening by a forensic physician. As Hampson points out, these professionals may not routinely be Section 12 approved but it remains the case that they can be more able at recognising non-psychiatric (in some instances, life-threatening) conditions (Grace 2010). With the development of Section 136 assessment suites, a broader training impetus should be placed on physical health assessment skills for medical and nursing staff working in them. Thus, while progress is to be embraced, it may be time for senior psychiatrists to dust off the stethoscope and revisit acute physical assessment skills. In a complex multiagency situation, we should also show leadership in insisting that the patients' physical healthcare takes primacy and that the standards of this are appropriately monitored.

Garden G (2005) Physical examination in psychiatric practice. *Advances in Psychiatric Treatment* **11**: 142–9.

Grace G, Christensen RC (2010) Comparing psychiatrists' and primary care physicians' knowledge of nonpsychiatric medicine. *Academic Psychiatry* **34**: 80–1.

Hampson M (2011) Raising standards in relation to Section 136 of the Mental Health Act 1983. *Advances in Psychiatric Treatment* **17**: 365–71.

Nicholas P. Swift, Associate Specialist, South Staffordshire and Shropshire Healthcare NHS Foundation Trust. Email: n.swift@nhs.net

doi: 10.1192/apt.18.1.78b

Author's reply

Swift's concerns that some senior psychiatrists may not have the skills to conduct a 'basic physical health assessment' should not be linked only to Section 136 assessments. Physical health problems presenting with behavioural disturbances may be seen acutely in the community too, and psychiatrists should be able to determine whether a presentation in a clinic setting could be due to or exacerbated by an underlying physical health problem. There are core skills that all doctors need, including the assessment of psychiatric disorders by our physician colleagues and physical health problems by ourselves. Trainees are examined on those skills in the Clinical Assessment of Skills and Competencies (CASC) examination and surely those who are trainers need to have sufficient skills to supervise them in this area too? The General Medical Council's (2006) *Good Medical Practice* states that 'it is the duty of the doctor to keep performance knowledge and skills up to date'. The College's guidance *Good Psychiatric Practice* notes that the psychiatrist should be 'competent in determining the necessary physical examination and investigations required for a thorough assessment' and that CPD activities should be undertaken 'that reflect the needs of their current and planned professional activities' (Royal College of Psychiatrists 2009). The College, through the Education & Training Centre, runs courses on updating physical health skills. If in doubt, the patient can receive a second opinion and can be transferred on the Section 136 to an emergency department if an urgent assessment is required.

When the necessity of employing expensive psychiatrists is being challenged, surely it behoves us to ensure that we retain the basic core skills we acquired in our medical training, as the ability to understand the sometimes complex interaction between physical and mental illnesses is an area in which we can demonstrate unique skills.

A problem relating to Section 136 and physical health has been addressed by the College (Royal College of Psychiatrists 2011). If a Section 12 approved doctor is not available without delay to assess the physical health of Section 136 patient, a more junior doctor can be called to address immediate physical health and risk issues. This does not amount to the formal medical assessment under the Mental Health Act, which should be undertaken by a doctor approved under section 12(2) of the Act.

General Medical Council (2006) *Good Medical Practice*. GMC.

Royal College of Psychiatrists (2009) *Good Psychiatric Practice (3rd edn) (College Report CR154)*. Royal College of Psychiatrists.

Royal College of Psychiatrists (2011) *Standards on the Use of Section 136 of the Mental Health Act 1983 (England and Wales) (College Report CR159)*. Royal College of Psychiatrists.

Michele Hampson, Consultant Psychiatrist and Co-Clinical Director for Adult Mental Health Services, Nottinghamshire Healthcare NHS Trust, Psychiatric Out-Patients, B Floor South Block, Queen's Medical Centre, Derby Road, Nottingham NG7 2UH, UK. Email: Michele.Hampson@nottshc.nhs.uk

doi: 10.1192/apt.18.1.79

Corrections

CORRECTIONS

Sarkar J (2011) Short-term management of repeated self-harm in secure institutions. *Advances in Psychiatric Treatment* **17**: 435–46.

Dr Sarkar's email address is sarkarjay68@gmail.com

Polnay A (2011) Bewilderment and conviction: the portrayal of madness in Ondaatje's *Coming Through Slaughter*. *Advances in Psychiatric Treatment* **17**: 451–3.

In Fig. 3, Buddy Bolden is standing second from the right.

doi: 10.1192/apt.18.1.79a