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the columns correspondence

Review of on-call duties of non-consultant hospital doctors in a rural Irish psychiatric unit

The European Working Time Directive is a welcome challenge to traditional out-of-hours medical working practices, and aims to safeguard both doctors' and patients' health and safety. Its implementation is delayed in the Republic of Ireland because of ongoing medical union negotiations. Implementation of the directive will mean examination of on-call rotas, training requirements, and the organisation of cover. Local data determining clinical workloads after hours are the starting point to identify areas of concern and to implement appropriate solutions in individual locations.

We examined the out-of-hours calls of non-consultant hospital doctors (NCHDs) from 17.00 h to 09.00 h on weekdays and all day at weekends over a 4-week period, representing a total of 512 h. After midnight, the number of calls to doctors was less than a sixth the number before midnight (10 v. 64%). The majority of calls (68%) were for patient assessment and review, but a significant proportion related to non-medical work such as phlebotomy (8%) and filing (1%), and non-urgent work, such as the rewriting of prescriptions and the charting of medication (16%). Of all calls, 88% were appropriate to the skill level of the doctor contacted, however 9% required less skill and 2% were judged to be non-medical. Only 1% of calls were from general practitioners.

The restricted access of NCHDs to clinical supervision and training opportunities

with shift working could be mitigated by high quality training in the evening and a reduction in time spent on non-training tasks. The new models of working are an opportunity to improve coordination of care between medical, nursing and other staff. Resources must be focused on the correct solutions, not just recruitment of additional medical staff. Above all, current available services and quality of patient care and safety must not be compromised.

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Training of senior house officers

In their recent paper Callaghan *et al* (*Psychiatric Bulletin*, February 2005, **29**, 59–61) showed that senior house officers (SHOs) in psychiatry usually valued on-call periods as a learning experience. However, the European Working Time Directive regulations regarding hours worked and rest requirements are now well and truly upon us and this has caused concern regarding the training of SHOs in other specialties (Mayor, 2005).

In Nottingham, SHOs in psychiatry previously worked a high intensity shift pattern that did not adhere to European Working Time Directive regulations. Measures implemented to ensure adherence to the new regulations included the appointment of psychiatric nurses to work

specifically at night as the first point of call for anyone referring to the psychiatric SHO. Initially SHOs were involved with the majority of the assessments but over time the nursing team's experience has increased and they are now proficient in managing almost all of the referrals independently. As a consequence, SHOs are now finding that their participation in acute decision-making, risk assessment and devising management plans has reduced significantly.

The movement of specialist nurses into the role traditionally fulfilled by SHOs should not act as a barrier to training. Additional measures need to be introduced to ensure SHOs remain exposed to acute psychiatric cases. Possibilities include nursing teams providing direct training and a more comprehensive trainee's logbook where emergency cases seen are recorded. This would also be a step towards workplace assessment for doctors in training which is emphasised in *Modernising Medical Careers* (Department of Health, 2002).

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Psychiatry and the pharmaceutical industry

We read with interest the editorial 'Dancing with the Devil? A personal view



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of psychiatry's relationship with the pharmaceutical industry' (*Psychiatric Bulletin*, March 2005, **29**, 81–83) as we feel it has much relevance for developing countries such as Sri Lanka. It appears that the pharmaceutical industry employs different methods when dealing with developing countries; these include the provision of poor details of products which sometimes lead to deleterious effects.

The pharmaceutical industry and the medical profession mainly interact through the sales promotion of drugs and symposia organised by pharmaceutical companies. The industry influences prescribing patterns through drug promotion but, if interactions between doctors and drug companies are transparent, no impropriety will be alleged (Breen, 2004).

Large scale commercial trials are still not conducted in Sri Lanka although help is often given informally (either money or equipment). However this may change as more companies look towards developing countries to carry out clinical trials because of the low cost and availability of human resources.

Research funded by pharmaceutical companies is less likely to be published and is more likely to have an outcome favourable to the sponsor (Lexchin *et al*, 2003). Nevertheless, the interaction between academia and the pharmaceutical industry is valuable but should be regulated by academic departments (Montaner *et al*, 2001).

In many developing countries clinicians rely on drug treatment more than in the west due to a shortage of human resources for time-consuming psychological therapies. However, although psychiatrists in developing countries may be more vulnerable to undue influence by pharmaceutical companies, we believe that the governing ethical principle that our primary obligation is to the patient will guide us to be independent and help us follow rational prescribing practices.

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Lessons from the UK diamorphine shortage

The article by Luty (2005), together with the two commentaries (Carnwath, 2005; Gilvarry, 2005), does much to reveal the intricacies of the debate concerning injectable diamorphine prescribing. Unfortunately, none of the articles mentions the fact that since December 2004 supplies of injectable diamorphine in the UK have been diverted away from addiction services due to a failure in production at the plant of the main manufacturer: Chiron.

In Cornwall we had 51 clients in receipt of such a prescription, all of whom had already been tried on optimised methadone maintenance, and two-thirds of whom were stable and not using street drugs. When the shortage started to affect our local pharmacies, 43 of these clients were converted to a part-injectable methadone prescription. All 43 complained of side-effects and, using a questionnaire, keyworkers identified other 'serious undesirable consequences' in 41, with 35 clients admitting to increasing or restarting street heroin use. Clients who were not switched to methadone had diamorphine solution or tablets, or higher strength ampoules, which were on the whole much better tolerated.

The experience has confirmed to local clinicians the value of diamorphine by whatever route, particularly in those that do not tolerate methadone well.

The disruption that has been caused by the supply failure has been considerable and we have been disappointed that the Department of Health appears to have had so much difficulty in procuring adequate additional supplies, or even in giving a reliable date as to when normal supplies will return. This uncertainty is adding considerably to the ongoing

difficulty of planning safe and effective treatment for our clients.

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Do we really need a duty consultant?

As much as I would like to agree with Riordan's proposal that consultant psychiatrists provide only telephone advice rather than a conventional out-of-hours service (*Psychiatric Bulletin*, May 2005, **29**, 193–194), I am afraid he does not take into account one of the core duties when on call. This involves carrying out assessments under the Mental Health Act 1983 for which there is no alternative than a face-to-face interview. In my experience most requests come from police stations for assessments of people who have been taken to the cells as a place of safety if they appear to be suffering from a psychiatric disorder or have been arrested for an offence. Recent British Medical Association guidance (BMA, 2004) emphasises the desirability of using alternatives to prosecution, such as admission to hospital, where detainees have a psychiatric disorder and it is not in the public interest to prosecute. Without a duty consultant available to make direct mental state examinations, these patients and other urgent cases in the community would be left suffering overnight which, depending upon their risk behaviours, could result in potentially disastrous outcomes.

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