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?

Michael Gotz Consultant Psychiatrist, **Robert Clafferty** Consultant Psychiatrist, Kildean Day Hospital, Drip Road, Stirling FK8 1RW

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)

Stephen S. Barlow MB ChB, MRCPsych Consultant Forensic Psychiatrist, The Hutton Centre, St Luke's Hospital, Middlesbrough

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 (EBJC) to teach critical appraisal skills, but what is an EBJC?

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 EBJC 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.

Nicholas Walker Consultant Psychiatrist, Renfrewshire and Iverclyde Primary Care NHS Trust, Mental Health Directorate, Ravenscraig Hospital, Inverkip Road, Greenock PA16 9HA

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

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quote the following extract from their website (http//:www.mhac.trent.nhs.uk/hospreport2000.pdf).

> "In 1998/99 there were 4245 managers' reviews where detention was contested, resulting in 338 (8%) discharges. In 1997/98 there were 3598 contested reviews and 324 (8.2%) patients discharged following a managers' review."

Second, contrary to the impression created by your editorial, sadly, patients are not currently allowed to apply for legal aid to enable them to be represented at managers' hearings. This support is only provided for mental health review tribunal hearings.

Patricia Gregory Kingston & District Community NHS Trust Chairman, Woodroffe House, Tolworth Hospital, Red Lion Road, Surbiton, Surrey KT6 7QU

Changes in the practice of electroconvulsive therapy

Sir: Having abandoned the use of electrolyte solution in favour of gel, our local monitoring and recording systems showed a marked increase in impedance. Despite adequate skin preparation and electrode placement and the use of greater mechanical pressure in the application of the electrodes, impedance levels remained higher by a factor of approximately times four compared to previous levels.

As impedance provides a measure of the resistance to current flow from the electrode to the patient, the change in method (and hence impedance) is likely to necessitate a significant increase in the current required for effective treatment (Royal College of Psychiatrists, 1995).

In addition, increased side-effects may be a result. The two patients treated during the cross-over period complained of significantly more side-effects of headache, memory impairment and general feelings of 'unwellness' when the impedance levels rose.

For the time being, in the absence of better evidence, we have chosen to return to the use of pads and electrolyte solution for the comfort of our patients.

ROYAL COLLEGE OF PSYCHIATRISTS (1995) *ECT Handbook: The Second Report of the Royal College of Psychiatrists Special Committee on ECT.* Council Report CR39. London Royal College of Psychiatrists.

Sara Smith Specialist Registrar in General Psychiatry, Redditch, **Agnes Nalpas** Consultant Psychiatrist responsible for ECT, Kidderminster Hospital

the college

Nominees elected to the Fellowship and Membership under Bye Law III 2 (ii)

At the meeting of the Court of Electors held on 20 February 2001, the following nominees were approved.

The Fellowship

Dr Syed Wasi Akhlaq Ahmad; Dr Mohammed Hussain Ali; Dr Saravanamutta Ananthakopan; Dr Karl Michael Asen; Dr Rosemary Anne Baker; Dr Donald Francisco Bermingham; Dr Anne Stuart Bird; Dr Andrew Kilgour Black; Dr Dawn Black; Dr Patrick Farrar Bolton; Dr Nisreen Hanna Booya; Dr Andrew Frederick Clark; Dr Peter Richard Cohen; Professor Sally Ann Cooper; Dr Michael Gregory Curran; Dr Ahmed Kasem Darwish; Dr Ian Alexander Davidson; Dr Thomas Richard Dening; Dr Salah El Din Rashwan Aboul Fadl; Dr David John Findlay; Dr Fiona Craig Margaret Forbes; Dr Pauline Marie Forster; Dr Graham Reginald Gallimore; Dr Catherine Anne Gillespie; Dr Merajuddin Hasan; Dr David Vaughan James; Dr Josanne Holloway; Dr George Ikkos; Dr Ziad Subhi Issa Jabarin; Dr Shantha Leicester Wijayasingha Jayewardene; Dr George John; Dr Philip Lewis Alan Joseph; Dr Rajkumar Hiralal Kathane; Dr Kalyani Katz; Dr Peter Hammond Kay; Professor Anthony Robert Kendrick; Dr Henry Gerard Kennedy; Dr Sean Patrick Lennon; Dr Gillian Avril Livingston; Dr Mervyn London; Dr Clare Joan Mary Lucey; Dr Donald Lyons; Dr Andrew James McBride; Dr Graeme Harding McDonald; Dr David Robison Craig McVitie; Dr Chinta Mani; Dr Diana Patricia Morrison; Dr Matthijs Frederik Muijen; Dr Martin William Orrell; Dr Alastair Noel Palin; Dr Mary-Jane Pearce; Dr Sanjay Rastogi; Dr Brian Robinson; Dr Michael Alexander John Rosenberg; Dr Packeerrowther Thulkarunai Saleem; Dr Kishore Santa Kumarsingh Seewoonarain; Dr Aman Ullah Shaikh; Dr Keshar Lal Shrestha; Dr William Gerard Smith; Dr Nicholas Geoffrey Dare Sorby; Dr David George Sumners; Dr Kolappa Sundararajan; Dr Timothy Charles Ayrton Tannock; Dr Muthusamy Subramaniam Thambirajah; Dr Christopher James Thomas; Dr Mohan George Thomas; Dr Guinevere Tufnell; Dr Timothy Ewart Webb; and Dr Francis Edgar Winton.

Fellowships – overseas

Dr Muhammad A-Hamid Salih Al-Samarrai; Dr Moshe Avnon; Professor Siegfried Kasper; Dr Frank Gitau Njenga; Dr Farouk Ahmed Randeree; and Dr Jeffrey David Thompson.

The Membership

It was agreed that the following should be awarded Membership under Bye Law III 2 (ii):
Dr David James Burke; Dr Tom Fryers; Professor Mohamed Hamed Ghanem; and Professor Jude Uzoma.

Learning objectives for child and adolescent psychiatry and learning disability placements at senior house officer level

Introduction

A 6-month placement in child and adolescent psychiatry and/or the psychiatry of learning disability is now a mandatory part of basic specialist training in psychiatry. Although candidates may sit the MRCPsych examination before such a placement or while completing it, the MRCPsych cannot be awarded (and the candidate cannot proceed to higher specialist level training) until the placement has been satisfactorily completed.

The rationale for such a mandatory placement is that all qualified psychiatrists need to have a proper understanding of the developmental basis of psychiatric practice. To achieve this they not only need the relevant theoretical knowledge but also to have had the clinical experience of working with both children, adolescents and their families and with people with a learning disability and their families.

The main purpose of clinical placements in child and adolescent psychiatry and/or the psychiatry of learning disability is to complement trainees' theoretical learning on local MRCPsych courses. It is critical that trainers of senior house officers (SHOs) in these specialities concern themselves primarily with the learning objectives of a general psychiatrist-in-training, rather than view this as the beginning of higher training. Some trainees will take advantage of the placement to study a preferred subject in depth, but this enthusiasm should not detract from the main aims of the placement, which are to equip psychiatrists pursuing a general psychiatry career or entering another speciality with the skills necessary to recognise the need for a more specialist input, and also to consider their patients' presentation in both developmental and systemic terms.

The faculties of child and adolescent psychiatry and of learning disability have worked together to produce educational objectives for these mandatory place-

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