two allocated sessions a week to deal with any physical problems on the rehabilitation wards, and this shared-care approach, similar to that described in *APT* by Lester (2005), is valued by both patients and staff. It also ensures that long-term psychiatric patients receive adequate screening.

With new guidelines constantly being issued on the checks we should be performing on patients taking psychotropics and the ever-present threat of medico-legal implications, I feel it is time that more emphasis in our training be placed on physical examinations, with regular refresher courses – perhaps similar to advanced life-support courses – even after membership. This must also involve psychiatric nursing staff, who usually have only basic 'physical' training: perhaps the Royal Colleges of Nursing and Psychiatrists should jointly look into this. A combination of the shared-care approach by primary and secondary services and an increased emphasis on teaching psychiatrists and psychiatric nurses about physical illnesses is, in my opinion, the best way to look after the holistic well-being of our patients.

By the way, for those of you who always wanted to know how to calculate the QTc interval but were afraid to ask, I found this formula in Kumar & Clark's *Clinical Medicine*:

> QTc = QT interval divided by the square root of the R-to-R interval

Now you just have to know how to read an ECG!

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Author's response

Dr Kunar raises two main issues in his letter, namely maintaining psychiatrists' competence in physical examination and delivery of good physical care for patients with mental health problems.

Development of registers of patients with serious mental illness and proactive involvement of primary care clinicians in the physical care of patients with mental health problems are to be welcomed. However, notwithstanding input from primary care, Dr Kunar rightly emphasises the requirement for psychiatrists to understand and to monitor the medical effects of medication and the need to maintain skills in physical medicine in order to do so.

The complexity of the skills required to perform a proficient physical examination and the need to maintain or revive these skills present no easy task for psychiatrists. Trainees should have an advantage, being less removed from their basic medical training as students or house officers. However, without supervision, skills in physical examination dwindle. I suspect that many trainees have no training devoted to this subject in their educational programmes or posts.

How can this situation be addressed? A video of physical examination targeted at psychiatrists would undoubtedly be useful, and if funding is forthcoming, it is hoped that this possibility will become reality. However, just as with playing tennis or a musical instrument, knowledge of what to do is not synonymous with personal competence.

There is no substitute for carrying out regular physical examinations and having technique refined by expert (not peer) observation and assessment. Liaison with colleagues in medicine and primary care might allow training posts in old age, liaison and rehabilitation psychiatry to evolve to incorporate refreshment of physical examination skills. Alternatively, part of the formal teaching programme for trainees could include practical sessions with a local primary or secondary care clinician.

The question of maintenance of physical examination skills in consultant or non-career grade staff is altogether more contentious. Scepticism about the need to maintain competence in this area, the evolution of specialist mental health services and lack of time are likely to be significant obstacles. Realistically, there will be no comprehensive progress in this group unless a more holistic approach to patient care is valued, posts have realistic case-loads to enable such care to be delivered and maintenance of skills to deliver is enshrined in CPD.

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