J. H. J. Walton), pp. 181–191. Montreal: Heol Publications.

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Psychotherapy experience for trainees

Sir: Debate within the College has suggested that compulsory psychotherapy experience for psychiatric trainees would lead to an erosion of opportunity for research experience. Published research is widely seen as a prerequisite for progression through the training grades (Duffet, 1994), yet concern has been raised as to whether it is feasible for trainees to pursue meaningful research before moving into the specialist registrar/senior registrar grade (Timini, 1995). It may be that trainees involved in research are doing so at the expense of psychotherapy training or vice versa. An alternative, but perhaps less charitable, viewpoint is that while some trainees are keen to do both research and psychotherapy, others consistently manage to avoid doing both.

To investigate this further we conducted a questionnaire survey of psychiatric trainees at registrar level training with the South Thames (West) training scheme based at St George's Hospital, Tooting, South London. All registrars training in psychiatry in the Region in 1995–1996 received a two-part questionnaire. The first part focused on how many psychotherapy cases the trainee had treated, subdivided into modalities including cognitive–behavioural and individual psychodynamic psychotherapy. The second part of the questionnaire asked about the number and type of research projects the trainee was involved in.

Fifty-four questionnaires were received from 56 trainees giving a response rate of 96%. Direct involvement in research activity was claimed by 79% of the sample; 93% had treated one or more cognitive–behavioural cases, while 85% had treated one or more individual psychodynamic cases. Kendall's tau correlation coefficients showed no association between number of research projects and number of individual psychodynamic cases treated (τ=0.092, P=0.404). There was, however, a significant correlation between number of research projects and number of behavioural cases treated (τ=0.336, P=0.003).

These findings do not support the idea that trainees who make time for treating psychotherapy cases do so at the expense of research involvement. Trainees treating cognitive–behavioural psychotherapy cases appear able to combine activity in both and should continue to be encouraged to do so.

DUFFET, R. (1994) Publication by junior doctors: why do they do it? *Psychiatric Bulletin*, **18**, 553–554.
TIMIMI, S. (1995) Trainee psychiatrists' theoretical vacuum (letter). *Psychiatric Bulletin*, **19**, 707.

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Evidence-based medicine

Sir: I read with interest Schmidt *et al*'s editorial on evidence-based medicine (EBM) (*Psychiatric Bulletin*, December 1996, **20**, 705–707). I would like to add a few pertinent details from Sacket *et al* (1996) (also listed in Schmidt *et al*'s article).

Sacket (Director of NHS Research & Development Centre for EBM, Oxford, UK) and co-workers use a comprehensive definition of EBM: ". . . the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients". Its practice ". . . means integrating individual clinical expertise with the best available external evidence from systematic research". If there is no available evidence that fulfils gold standards, then ". . . we follow the trail to the next best external evidence and work from there".

Schmidt *et al* depict a scenario where insisting on the best option may augment a patient's resistance to treatment or affect the doctor–patient relationship. A clinical decision process must include the patient's relative preferences (i.e. utilities), or better still, the values that the patient assigns to such utilities. Only when a patient cannot do this might the clinician alone quantify these utilities. In either situation, the final decision may not necessarily favour the option best supported by the external evidence. Thus, Sacket *et al* argue that external clinical evidence ". . . can never replace individual clinical expertise and it is this expertise that decides whether the external evidence applies to the individual patient at all, and, if so, how it should be integrated into a clinical decision"; that is, EBM strengthens but does not supplant clinical expertise.

Schmidt *et al*'s assumption that many will feel unable to appraise research articles critically is not a strong argument to dismiss EBM. For many it may take some practice to become proficient, but the same applies to the development of most other skills.

SACKET, 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.

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Providing a psychiatric service to liver transplant patients

Sir: Mitchell *et al* (*Psychiatric Bulletin*, January 1997, **21**, 6–9) give an interesting description of their work providing a psychiatric service to liver transplant patients at the Edinburgh Royal Infirmary. They argue that a psychiatric opinion should be sought in all cases of assessing suitability for liver transplantation. We have been considering our work with liver transplant patients at the Bristol Royal Infirmary.

By assessing all transplant patients pre-operatively, psychiatrists are drawn into the complex and largely opaque process of the allocation of scarce resources. We have concerns about the consequences of diagnosing a mental illness in a patient *en route* to liver transplantation. Mitchell *et al* considered one patient too depressed to cope with the operation and advised against transplantation. This raises some difficult ethical questions for psychiatrists. Who can and should allocate scarce resources? On what grounds should these choices be made? Should we participate in the denial of a patient in end-stage liver failure the only real hope of survival?

Surman (1989) describes successful outcomes after transplant surgery for a number of patients with psychosocial problems. Rather than assessing all patients for suitability for transplant surgery, we advocate concentrating resources on the few patients who need specialist support through the stress of the procedure.

SURMAN, O. S. (1989) Psychiatric aspects of organ transplantation. *American Journal of Psychiatry*, **146**, 972–982.

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Section 3 – hidden consequences

Sir: Detention under Section 3 of the Mental Health Act may have consequences not only for the patient, but also for relatives, staff and other patients. Consider an elderly, confused, informal patient awaiting nursing home placement. Having wandered and been returned with some coercion, Section 5(4) was implemented, because he was on a psychiatric ward. Successive Sections resulted, although it was paradoxical that a man fit to leave hospital was being detained.

Paperwork, resulting solely from use of the Act, can be quantified. Section 5(4) led to four forms and reports (six copies); 5(2) generated nine forms, rights leaflets, etc. (two copies); Section 2 led to 47 forms, pages of reports to managers and tribunal, etc. (135 copies); Section 3 produced 54 pages of reports, appeal decisions, leave forms, Form 39, MHAC I, etc. (149 copies). This gave a total in this complicated, but not unusual, case of 114 original pages and 292 copies. Aftercare (Section 117) paperwork is not included.

Financial considerations are most relevant. He was able to afford his fees – already agreed. However, Section 3 leads to Section 117 aftercare when fees (over £300 a week) are fully met by the local authority – indefinitely, since dementia does not improve! A further apparent advantage is speed of discharge as priority appears to be given to patients "detained against their will" over those "informally waiting" in hospital. Other patients may feel disadvantaged. The additional costs of full Section 117 meetings in nursing homes are not insignificant. Pressure not to discharge from Section 117 is felt, since to do so passes the full bill to patient and family.

The impression gained is that articulate, financially successful men tend not to accept confinement to a ward. Section then ensues, and fees are met. Those with more limited financial resources may be more compliant, and their relatively smaller savings are used for their care. Perhaps knowledgeable families realise the benefits Section 3 brings! If all demented people were deemed unable to consent to care, all might currently benefit from Section 3, to the disadvantage of non-demented nursing home applicants. Should the financial benefits of Section 3 status be retrospectively paid? Public funds should not be used for people solely because they happen to have been detained under Section 3, a major procedure which can be, in this group of patients, surprisingly arbitrary in application.

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