the columns

correspondence

Modernising medical careers

Dr Herzberg and colleagues (*Psychiatric Bulletin*, July 2004, **28**, 233–234) describe the forthcoming Foundation Programme changes as a 'win–win' position for psychiatry. My own view is a great deal more pessimistic.

It is certainly the case that, at an early stage in their postgraduate careers, more young doctors will be getting an exposure to psychiatry (usually of four months' duration), and this may well increase the numbers of keen and appropriate applicants for specialist senior house officer (SHO) posts in psychiatry. However, in Scotland, it seems clear that Foundation Year 2 placements in psychiatry will be generated by sacrificing those same specialist SHO posts. Locally, for example, we are likely to reduce from 21 to 16 career SHOs on the Aberdeen training scheme. The changes give rise to no additional funding and, unlike in the English Deaneries, there are no plans here to create extra SHO posts.

While increasing excellence and numbers of applicants for specialist SHO posts will help, it is not the major issue with regard to the depleted consultant workforce. As the College's recent survey (Mears *et al*, 2002) demonstrated, of 100 trainees who actually get as far as sitting Part 1 MRCPsych, only about 40 will end up as consultant psychiatrists. Essentially, there are too few SHOs becoming specialist registrars. Locally, we have a shortage of applicants for specialist registrar posts, but have more than adequate numbers of good applicants for SHO posts. The Foundation Programme can only exacerbate this imbalance through reducing specialist SHO numbers.

There is an additional consideration for the shortage 'sub-specialty' of general adult psychiatry. It is likely that Foundation Year 2 training placements will be predominantly in psychiatry, displacing current career SHOs. These rapidly rotating, inexperienced trainees will place further strain on the service and upon already stressed consultants, potentially making the specialty even less attractive to potential specialist registrars, lowering consultants' retirement ages further, and generally compounding our recruitment and retention problems.

I would regard the views expressed by Dr Herzberg and colleagues to constitute complacent optimism. I really do hope that such views about the Foundation Programme changes are not mirrored in the College and that all possible steps will be taken to attempt to prevent reductions in specialist SHO training posts.

MEARS, A., KENDALL, T., KATONA, C., *et al.* (2002) *Career Intentions in Psychiatric Training and Consultants (CIPTAC)* (College Research and Project Report). London: Royal College of Psychiatrists.

John M. Eagles Consultant Psychiatrist, Royal Cornhill Hospital, Aberdeen AB25 2ZH

Staff attitudes to smoking in an Irish mental health service

Stubbs *et al* (*Psychiatric Bulletin*, June 2004, **28**, 204–207) found that the majority of mental health staff in an in-patient setting did not favour a total ban on smoking. In the context of the ban on smoking in enclosed workplaces introduced in the Republic of Ireland in March 2004 [Public Health (Tobacco) (Amendment) Act 2004], the smoking policy committee of our mental health service in the Northwest of Ireland conducted a survey seeking the views of, among others, staff (n=174, 28% smokers) prior to its introduction. The legislation exempts patients (but not staff or visitors) in psychiatric hospitals. Of the respondents, 89% were in favour of the ban being implemented throughout our mental health service despite 78% believing that this would prove difficult or very difficult. Support for the ban among smokers was less (77%), although still quite high.

The Irish legislation has provoked much debate in Ireland and elsewhere since its introduction and public support has been remarkably high with 82% of Irish people still in favour five months after its implementation (Irish Department of Health, http://www.dh.gov.uk/assetRoot/04/08/66/57/04086657.pdf August 2004). Our findings appear to reflect the overall attitude of the Irish people toward the smoking ban in public places rather than those of the mental health staff surveyed by Stubbs *et al*. As this important public health debate develops in the UK, it is incumbent upon mental health professionals to add their voice, particularly in relation to the issue of whether to exempt mental health facilities from any proposed smoking legislation.

***Edmond O'Mahony** Consultant Psychiatrist, Sligo Mental Health Service, Sligo, Republic of Ireland, **Farukh Rahmani** Senior House Officer in Psychiatry, Sligo Mental Health Service, Sligo, Republic of Ireland

Research activity of specialist registrars in psychiatry

Petrie *et al* (*Psychiatric Bulletin*, 2004, **27**, 180–182) identify many of the negative aspects of conducting research as a trainee. However, an opportunity has been missed to examine the type of research being conducted and trainees' opinions on the positive aspects of doing research. In our opinion, research taught us more about juggling competing demands, negotiating skills, ethical dilemmas and organisational competence than any other experience as a psychiatric trainee. If research sessions were used for another purpose (as more than half the responders wished) this valuable training opportunity would be lost. A consultant needs much more than just clinical skills.

Further, using successful publication as an outcome measure of research sessions ignores the many other benefits research can provide. To those benefits noted above should be added the understanding of the process of project development, increased knowledge in the area of study, an appreciation of the demands of academic and clinical roles and transferable skills such as information technology, writing skills and independent working (Hull & Guthrie, 2000). We had both finished our training before definitive publications in major journals were published, but neither felt our time had been wasted.

Interesting findings in this survey include the relatively small numbers of trainees who had difficulties recruiting subjects (10, 31%) and funding (4, 12%).

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columns

As both issues tend to be problematic for even the most experienced and battle-hardened researcher is this a reflection of the sort of studies being conducted? Of course, to participate in larger studies would include the attendant risk of delayed or indeed no publication!

Declaration of interest

A.M.H. and M.G. both undertook full-time research placements as higher trainees.

HULL, A. M., GUTHRIE, M. (2000) Full time research placement as a higher trainee. *BMJ*, **320**, s2–7249.

Alastair M. Hull Locum Consultant Psychiatrist, Murray Royal Hospital, Muirhall Road, Perth PH2 7BH, **Moyra Guthrie** Consultant Psychiatrist & Clinical Director, Murray Royal Hospital, Perth

Mental health review tribunals and legal representation – equality of arms?

Due to the influence of the European Convention on Human Rights and Fundamental Freedoms and the enactment of the Human Rights Act 1998, quite properly, virtually all patients are legally represented in Mental Health Review Tribunals. Indeed, the European Court of Human Rights has decided that in certain circumstances patients' rights may be breached if they are not represented in proceedings, even when, in fact, they have not requested a lawyer (Megyeri *v.* Germany, 1992). However, it is important to note that both sides of tribunal proceedings are not treated equally.

One of the basic tenets of justice is the concept of equality of arms, i.e. 'a reasonable opportunity of presenting the case to the court under conditions which do not place him in substantial disadvantages vis-à-vis his opponent' (Kaufman *v.* Belgium, 1986). The expression of this in regard to tribunals is enshrined in Article 5(4), (everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of this detention shall be decided speedily by a court and his release ordered if the detention is not lawful). It is the interpretation of this Article which has led patients to receive free legal representation in tribunals. What is anomalous, and indeed perverse, is that in England and Wales the detaining authority has no such legal representation and almost entirely relies on the Responsible Medical Officer to argue the case for continuing detention. It is theoretically possible for the Responsible Medical Officer to legally represent the detaining authority (R. on the application of Mersey Care Trust *v.* MHRT [2003]) but this could clearly never be to the same skill level as a trained solicitor or, indeed in certain circumstances, a barrister and rarely happens in practice. In an increasingly litigious and complex world, it not only appears amateurish and one-sided but, more significantly, the appropriate balance of the States' obligations and the patients' rights cannot be fairly struck, which cannot be in the best interests of either the patient or of society. In contrast, in Northern Ireland however, where the relevant legislation is largely based on the Mental Health Act 1983 (Mental Health (Northern Ireland) Order 1986), nearly all Mental Health Review Tribunals have legal representation for both the patient and the detaining Trust. From personal experience, this allows a fuller, more considered, and indeed expert, appraisal of the evidence. If this is good enough for one part of the United Kingdom, why not for another part and could this in itself be seen as discriminatory and thus, in itself, contrary to the Human Rights Act? Lack of resources are often cited as the reason for the Trust not to be legally represented but should certainly not be at issue here and the courts have already declared, in relation to tribunal delays, that the state has an obligation to fund important human rights issues irrespective of cost (R. *v.* MHRT and Secretary of State for Health, ex parte KB and others [2003]).

I suggest that this fundamental imbalance has been overlooked as an issue for far too long and is worthy of further debate and, hopefully, rectification.

Declaration of interest

I am a medical member of the Mental Health Review Tribunal.

KAUFMAN V. BELGIUM (1986) 50 D.R.98.

MEGYERI V. GERMANY (1992) Series A, No. 237-A; 15 E.H.R.R. 584.

R. ON THE APPLICATION OF MERSEY CARE TRUST V. MHRT (2003) EWHC 1182 (Admin).

R.V. MHRT AND SECRETARY OF STATE FOR HEALTH, EX PARTE KB AND OTHERS (2003) EWHC 193 (Admin).

John W. Coates Consultant Psychiatrist/Honorary Senior Clinical Lecturer, Rotherham General Hospital, Moorgate Road, Rotherham S60 2UD

Training within the European Working Time Directive

Now that 1 August has passed, all trusts should have implemented the hours and rest requirements stipulated in the European Working Time Directive (EWTD). This has been a challenge, and solutions have had to be creative; in psychiatry, many Trusts are attempting to reduce senior house officers (SHOs)' night commitments, rather than implementing a shift system akin to other specialties.

In order to reduce the night workload, responsibility for assessing and managing patients in accident and emergency (A&E) departments has shifted from the SHO, and is now more frequently done by nurse-led emergency teams. While a multidisciplinary approach is to be applauded, too often the SHO is not part of the process for fear of contravening the EWTD.

Assessing patients in A&E when on-call is invaluable for developing many of the skills that make a good psychiatrist, particularly risk assessment. Patients are seen when acutely unwell and sometimes it will be their first presentation. The patients in A&E often represent the more complex cases, with social problems and substance misuse as well as mental illness. Practice in dealing with these patients is crucial to developing psychiatric skills during the training period.

I feel if SHOs' exposure to patients in A&E is reduced in the name of EWTD compliance, training will suffer. To echo Sir William Osler, to train without reading books is to go to sea without any charts, to train without seeing patients is to not go to sea at all. I think that psychiatric trainees are in danger of missing the boat.

Charles Dixon Senior House Officer, Queen Elizabeth Psychiatric Hospital, Mindelsohn Way, Edgbaston, Birmingham B15 2QZ

Copying letters to patients

Sarah Hulin-Dickens (*Psychiatric Bulletin* (Correspondence) August 2004, **28**, 305) expresses considerable concern about the issue of copying letters to patients.

In contrast, my experience over 15 years of this practice is very positive. Parents are extraordinarily grateful and the patients themselves have no hesitation in correcting any errors and pointing out any omissions. The letters form a useful forum for further discussion, as well as a reminder of previous discussions. On no occasion have I ever received a complaint, either from a patient, a parent or any of the many professionals who receive copies of such letters.

This experience is shared by a number of colleagues and I hope that Dr Hulin-Dickens will feel reassured.

Bryan Lask Professor of Child & Adolescent Psychiatry, St George's Hospital Medical School, Department of Psychiatry, Jenner Wing, Cranmer Terrace, London SW7 0RE

Pharmacogenetics and addiction services

I support the view of Hodgson *et al* (*Psychiatric Bulletin*, August 2004, **28**,

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