Correspondence

The rights of patients regarding ethnic monitoring

Sir: I read with interest the letter from Dr Azuonye (*Psychiatric Bulletin*, 1994, **18**, 649–650) regarding ethnic monitoring.

The clinic in which I work serves one of the most multi-cultural populations in the country. The responsible NHS trust is introducing monitoring by showing patients a 'prompt card' with a list of 11 ethnic categories into which they are asked to classify themselves. The stated aim of this monitoring is "to be sure that our services are free from prejudice, so that everyone can use them equally and easily". If no ethnic choice is selected at first interview we are asked to repeat the above procedure at every subsequent patient contact. Although the expensively produced guides for clinicians using the card state that the patient may refuse to answer ethnic questions, there is no communication to patients on the card that they need not answer or that if they refuse, their care will be unaffected.

Patients may see psychiatrists because they have distressing symptoms which they regard as having little connection with ethnicity. Alternatively they may perceive their ethnicity as being of great importance in the way they and society see them and intimately connected with their life concerns. In the former situation questions on race may be experienced by them as irrelevant and in the latter as attacking.

Even if the measurement of ethnic groupings had some kind of proven internal validity, it is a simplistic assertion that, for example, if more Asian patients were referred to our clinic, racial prejudice, whether it be our own or that of the local community, had been overcome. Apart from the racism inherent in labelling others by ethnicity, it is a crude form of process audit masquerading as some measure of the quality of patient care. We as psychiatrists are increasingly being pressed by purchasers of health care to measure quantity as though it were equivalent to quality of psychiatric care. Such matters as ethnicity are complex and cannot be reduced to numbers and categories.

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AIDS education

Sir: The article by Dunn (*Psychiatric Bulletin*, 1994, **18**, 575–576) illustrates two separate approaches to AIDS education. While the *Sunday Times* is criticised for promoting a debate which questions accepted wisdom, the Brazilians are congratulated for promoting a message that "sex is good for physical and mental health" and "safe with a condom."

Tragically while the evidence that a heterosexual epidemic is taking hold in Brazil appears well substantiated, the evidence is that the Brazilian statements about condoms being "safe" are not correct.

The World Health Organization estimates that condoms only reduce infectivity of AIDS by a factor of 0.42 (Kelly, 1992). The report states that the latex used in condoms used in the West contain pores that are larger than the virus itself. If Brazilian condoms are indeed made of poorer quality latex then they will leak the virus even more. The failure rate in terms of conception with condoms is around 3.6% (Vessey *et al*, 1982) and higher for casual encounters. Given that women are fertile for less than 25% of the month and sperms are so much larger than the AIDS virus it can be seen that the condom is far from being a complete protection against the AIDS virus.

Commendable openness would therefore dictate that sex with a condom be described as "safer" or "less dangerous" but not "safe". If public health education campaigns continue to suggest that sex with anyone is safe provided a condom is used then we can only expect that the heterosexual epidemic will not be contained.

KELLY, J. (1992) Promoting sexual health. *British Medical Journal*, **305**, 363.

VESSEY, M., LAWLESS, M. & YEATES, D. (1982) Efficacy of different contraceptive methods. *Lancet*, **i**, 841–842.

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Expanding psychiatrists' role in the undergraduate medical curriculum

Sir: We echo Sensky's suggestion (*Psychiatric Bulletin*, 1994, **18**, 557–559) that psychiatrists have a greater role to play in the increasingly overcrowded and technologised medical

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curriculum. When our medical school was established in 1981, the teaching of the behavioural sciences course was run by one academic and one clinical psychologist and students' responses appeared unsatisfactory. Over the past two years, psychiatrists have taken over the course, which consists of a variety of lectures on medical psychology and sociology. The general approach is to teach basic psychological and sociological principles, illustrated with clinical examples. When one of us teaches Erikson's life stages during a lecture on 'young adulthood', for example, case histories are freely discussed of patients with depression, anorexia nervosa, etc. to illustrate how the failure to resolve conflicts earlier on in life may result in adult psychopathology. Students appreciate such 'story telling' as they seem to identify with clinicians more readily than with social scientists.

The course also includes a six-hour interviewing practical during which students in small groups interview patients and discuss communication skills. They are excited about visiting a clinical department, and are often as embarrassed as amused by teachers' feedbacks as they watch their awkward behaviours on the video monitor. That 'crazy' psychiatric patients can talk sensibly invariably makes a powerful impression on them. The whole exercise involves 120 teaching hours and is highly rated by students, one of whom wrote:

> "I felt that the practical is a golden chance for us to interact with patients in the preclinical years. Minor things that we usually neglect, such as greeting the patient politely, arranging the chairs, and using open ended questions, are in fact very important in doctor-patient communication or even everyday social interactions. It is exciting to see the faces of my classmates and myself on the monitor. There are so many awkward facial expressions and gestures to correct! After this practical, I have a much deeper understanding of the saying–to cure sometimes, to relieve often, and comfort always. I also learn that being a doctor does not merely mean book knowledge since medicine is a humanely conducted science."

We believe that a behavioural sciences course run by competent psychiatrists who continue to be keen to teach is an under-recognised source of enhancing students' attitudes towards psychiatric medicine.

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Validity of oral consent

Sir: I refer to the interesting case posed by Dr Alfred C. White (*Psychiatric Bulletin*, 1994, **18**, 507). I think the patient gave express consent in the form of oral consent which is legally as effective as written consent although obviously subjected to uncertainties. He willingly accepted ECT and thus gave implied consent. The consultant psychiatrist was satisfied that the patient understood the purpose, nature and consequences of the treatment offered. He appeared to have given sufficient information about ECT and the risks involved to satisfy the 'Bolam Test' (Bolam v Frien HMC 1957). Under the circumstances described I think oral consent was acceptable. I would suggest detailed records to be kept and a phone call made to the hospital's solicitors to confirm that the oral consent was valid.

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The Christopher Clunis enquiry

Sir: Jeremy Coid (*Psychiatric Bulletin*, 1994, **18**, 449–452) raised concerns about the ability of community services to protect the public from dangers associated with mental illness. However, I fear Coid has misinterpreted the main issue. He surmises, "The main importance of the Christopher Clunis enquiry is that it now poses very unpleasant questions about the ideology of health care delivery and the *routine clinical management of severely mentally ill persons* in the UK." (my emphasis). If I were a severely mentally ill person I would take great offence at his reasoning. The majority of severely ill patients are not dangerous. Dangerousness is not a feature associated solely with severity of illness. Some of the most dangerous patients I have dealt with are mild to moderately ill and of course the courts see many others who are not ill at all. The focus of concern should be how to manage those who (a) are chronically and intractably severely mentally ill and (b) have long-term problems with serious violence (as reflected in past serious acts of Clunis).

The main problems I have encountered in the community management of this group are:

(a) it does not take too long for clinicians to amass a worrying number of patients who may not only attack others but clinicians themselves. This erodes job morale

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