

out of the four out-patient teams only one is led by a non psychiatrist despite the added incentive of extra remuneration.

I would therefore conclude that it is not that doctors would like to take charge but that if we don't who will?

JOHN MATHAI, *Royal Children's Hospital, Melbourne, Victoria 3052, Australia*

Sir: I read with interest the article by Cottrell (*Psychiatric Bulletin*, 1993, 17, 733-735) on multidisciplinary teams in child and adolescent psychiatry. Child psychiatry is in a peculiar situation as team members take similar patients without much inter-disciplinary differentiation in their work-load. Whether a team member is a medically qualified practitioner, nurse, psychologist, or social worker, children who are depressed, miserable, anxious, phobic, enuretic, or have a conduct disorder or some other diagnosis are taken, and managed. Moreover, most teams seem to have developed an aversion to pharmacological treatment, and therefore do not see the need for the consultant to be kept aware of all patients under his or her care.

If all members of a multidisciplinary team can screen and carry out therapeutic work of a diverse nature, it is likely that soon the realisation will dawn on general managers that the expensive consultant psychiatrists who provide no special input can be dispensed from the multidisciplinary team and concentrated at the tertiary care level to handle the minute percentage of cases that the multidisciplinary team cannot (Arya, 1993).

The justification of consultant psychiatrist as team leader is now 'required' and is an issue of discussion in a multidisciplinary team. It may have nothing to do with the leadership qualities, medical responsibilities, salary or managerial expertise of the consultant but rather that, in child psychiatry now, other team members provide equivalent expertise. No doubt many psychiatrists are beginning to see "the possible benefits of preparing themselves for diffusing authority in order to facilitate a model of care which best meets the needs of our patients" (Cottrell, 1993). Surely, in a multidisciplinary team, a democratic leader can only have claim over leadership if he or she has the advantage of specific expertise.

ARYA, D.K. (1993) Child psychiatric services: in crisis? *British Journal of Hospital Medicine*, 49, 699.

DINESH K. ARYA, *Peter Hodgkinson Centre, County Hospital, Lincoln LN2 5QY*

Sir: I suspect that the differences between Dr Mathai and I concerning the functioning of multidisciplinary teams are not great but nevertheless significant. Where we both agree is that

teams must have leaders to function efficiently. I also agree that this leader will often be the doctor. However, I do not believe that the doctor should have this role as of right in out-patient teams. I note with interest that Dr Mathai is team leader in his own team, but only after having to apply for the post. I believe that doctors often make excellent team leaders, but that they are better able to fulfil this function, and in particular gain the support of the team, when that team has had a say in the leadership role, rather than when they feel that a leader has been imposed on them.

It follows from this that I would disagree with Dr Mathai's suggestion that the consultant decides to whom referrals should be delegated, after team discussion. I would argue that the team should make this decision after discussion which would, of course, allow the doctor an opportunity for his or her say.

Dr Arya is concerned that consultants may be withdrawn from multidisciplinary teams and held in reserve for dealing with that "minute percentage of cases that the multidisciplinary team cannot handle". This is to misunderstand the model of teamwork that I am proposing. The strength of the multidisciplinary team lies in the team's ability to bring the expertise of all team members to bear on any one referral and to support whichever team member is seeing that case. While it is important to recognise those areas of commonality in the skills of team members, it is equally important to recognise, and respect, those areas of difference which exist. The contribution of a medically trained psychiatrist is, like the contributions of other team members, essential to the effective functioning of the team. Without it the "minute percentage" of cases that the team could not handle would inevitably grow, as it would if any of the core disciplines were absent.

DAVID COTTRELL, *Academic Unit of Child and Adolescent Mental Health, 12A Clarendon Road, Leeds LS8 9NN*

Diagnosis of personality disorder

Sir: Like Dr Steadman (*Psychiatric Bulletin*, 1993, 17, 774), I have found the diagnosis of personality disorder to be used less frequently in recent years; however, I am not sorry to see its decline. In my experience the term is often inappropriate and rarely qualified by subtype or justified by evidence. It thus becomes a diagnostic label which rather than enabling appropriate treatment, actively discourages therapeutic intervention.

The rational alternative is to list specific problem areas in the patient's personality, giving appropriate examples. While this entails more time and effort than simply stating personality disorder (or more usually just 'p.d.'), it at least suggests a basis for treatment directed at specific areas of difficulty.

Concerning the practice of omitting personality disorder as a diagnosis from patients' notes in case they see them, it should be clear that the approach outlined above makes this unnecessary as it has much less potential to give offence. For example, if you point out to patients that they have difficulty controlling their anger, act impulsively and find it difficult to empathise with others – giving examples from their history, then they will probably agree with you and indeed may be impressed by your insight. Tell them that they are a psychopath however and you will not get the same reaction.

Dr Steadman felt confident in discharging a 'drunk' patient after reading the diagnosis personality disorder in the notes. But what confidence does such a label give us? It must be remembered that alcoholism and personality disorder are risk factors in both completed suicide and deliberate self harm, that patients with personality disorders may develop mental illnesses requiring hospital treatment, and that there is a duty of the doctor to act in the patient's best interests. Psychiatric diagnoses can also change over time.

I am sure Dr Steadman was correct to discharge his patient, but such decisions should be made on the basis of assessment at the time. Previous notes are useful as a guide to management, but past diagnoses should be treated with suspicion, and should have little bearing on decisions in the emergency situation.

ADAM KIRBY, *Southport and Formby Community Health Services NHS Trust, Hesketth Centre, 51–55 Albert Road, Southport PR9 0LT*

Training, manpower and employment in Australia

Sir: It was interesting to read Dr Kisely's article about psychiatric manpower and training in Australia (*Psychiatric Bulletin*, 1993, 17, 669–671) from my perspective as a British psychiatry trainee currently two months into a one year exchange post in Sydney.

Dr Kisely does not state from what perspective he has written his article – whether as an Australian working in Britain or vice versa – however, I would think he has not worked in New South Wales. It is important to emphasise that there are marked differences between the

six states and two territories in terms of mental health legislation service provision and arrangements for medical registration.

While Dr Kisely comments that arrangements for temporary work experience as part of training remain relatively straightforward. I found that arranging my visa and medical registration to work in Sydney time and finance consuming and, although hospitals in New South Wales may be happy to employ a British psychiatry trainee, the Immigration Department and Medical Board of NSW do not make things easy for them. The Medical Board of NSW grant "registration with conditions" when the applicant is exchanging work with an Australian psychiatric trainee or when the applicant can make a case that he or she is furthering his or her training by working in a designated post in New South Wales. When the Board have approved the position on the basis of these criteria the applicant can apply for a temporary residence visa which allows him or her to work on arrival in Australia. The applicant then has to present him or herself to the Board with documents and photographs and a cheque for \$A275.00 in order to gain a registration certificate which allows him or her to work only in the post to which he or she has originally applied for, and which disallows him or her from doing any private work, working as a locum or working in any other post. It is therefore a time consuming process with a number of potential stumbling blocks.

I would encourage trainees to come and work in NSW but I would advise them to make plans well in advance and to inform themselves fully of their prospective conditions of service.

ALCUIN WILKIE, *Westmead Hospital, Westmead NSW 2145, Australia*

Case conferences: an essential part of training in psychiatry

Sir: Rowlands & Geddes (*Psychiatric Bulletin*, 1993, 17, 363–364) emphasise the importance of journal clubs in the education of psychiatric trainees. Case conferences are a similarly important part of psychiatric training. It is recommended that such conferences take place weekly for a minimum of 30 weeks in the year (Royal College of Psychiatrists, 1987). It is therefore surprising that little attention has been paid to the subject in the psychiatric literature. Case conferences are an excellent way to learn presentation and interview skills. In addition they provide a forum for sharing knowledge and experience about the diagnosis and treatment of mental illness. Standard formats for presenting a case have been described (Vincenti, 1990; Holden, 1987). Sadly, at the