



the columns

correspondence

Sir: Harrington et al (2002), in their description of a one-day national survey of prescribing, speculate that poor documentation of the decision to prescribe high-dose antipsychotic regimes may be due to sub-optimal record keeping, lack of awareness that the regime was high-dose or both. We have recently completed an audit cycle, which sheds light on this issue in our unit.

We audited antipsychotic prescribing in Fromside Regional Secure Clinic for the whole of 2000 and again in the latter 6 months of 2001 (43 patients), against standards based on the Royal College Consensus statement (Royal College of Psychiatrists, 1993). The patients were male forensic detainees, all factors associated with the prescription of high dose regimes (Lelliott et al, 2002).

Our audit showed rates of high-dose prescribing of 19% and of polypharmacy of 35% in the first period, and 31% and 46% respectively in the second period. In the first period, a clear statement of indication and decision to prescribe a high-dose regime was included in only 25%, and an ECG had been performed in 0%. In the second, these standards were met in 0% and 25% of cases. Results of our first survey were presented to the teams involved and the standards circulated. It is therefore our suspicion that these poor results were due to a lack of routine prescription monitoring. We are incorporating monitoring procedures into prescription charts and case conference paperwork. Prescribing is a core medical responsibility; our patients deserve careful attention to detail.

HARRINGTON, M., LELLIOTT, P., PATON, C., et al (2002) The results of a multi-centre audit of the prescribing of antipsychotic drugs for in-patients in the UK. *Psychiatric Bulletin*, **26**, 414–28.

LELIOTT, P., PATON, C., HARRINGTON, M. et al (2002) The influence of patient variables on polypharmacy and combined high dose of antipsychotic drugs prescribed for in-patients. *Psychiatric Bulletin*, **26**, 411–14.

ROYAL COLLEGE OF PSYCHIATRISTS (1993) *Consensus Statement on the use of High Dose Antipsychotic Medication*. Council Report CR26. London: Royal College of Psychiatrists.

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Gay and lesbian partners of mentally ill patients

Sir: It is pleasing to note that one discriminatory aspect of law reported by the College's Gay and Lesbian Special Interest Group (Bartlett et al, 2002) was recently overturned in the courts.

In *R on the application of SSG and Liverpool City Council and Secretary of State for Health* (CO/1220/2002, finalised on the 7 November, 2002), the court declared that the homosexual partner of a patient can be treated as falling within the phrase 'living with the patient as the patient's husband or wife as the case may be' in s26(6) of the Mental Health Act 1983.

This means that it is now possible to construe same-gender partners as equivalent, both in meaning and in effect, to 'husband or wife' at s26(1) of the Act. Same-sex partners so construed can, therefore, now be recognised as having priority when determining the identity of a patient's nearest relative.

BARTLETT, A., WARNER, J. & KING, M. (2002) Gay and Lesbian Special Interest Group: nearest relatives of gay men and lesbians. *Psychiatric Bulletin*, **26**, 437–438.

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Altruistic suicide: precedence in usage

Sir: Dr Spencer's correspondence 'The Suicide Bomber – Is it a psychiatric phenomenon?' (*Psychiatric Bulletin*, November 2002, **26**, 346) perpetuates the belief that Durkheim was the first to use the term altruistic suicide. Altruistic suicide was described by George Savage as 'To save others from suffering. To benefit others', in his chapter on suicide and insanity in Tuke's *Dictionary of Psychological Medicine* in 1892. Furthermore, the notion of suicide as self sacrifice was also described by Mercier in his book *Sanity and Insanity* in 1890.

Whilst the concept of altruistic suicide is usually attributed to Durkheim, the

evidence is persuasive that Savage deserves scientific precedence in the use of this term. This has been discussed further in *Pre-Durkheim Suicidology: The 1892 Reviews of Tuke and Savage* (Goldney and Schioldann, 2002).

GOLDNEY, R. D., SCHIOLDANN, J. A. (2002) *Pre-Durkheim Suicidology: The 1892 Reviews of Tuke and Savage*. Adelaide, Adelaide Academic Press.

MERCIER, C. (1890) *Sanity and Insanity*. London, Walter Scott.

TUKE, D. H. (1892) *A Dictionary of Psychological Medicine*. London, J. & A. Churchill.

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On compassion for the SHOs

Sir: I run a weekly group for senior house officers (SHOs) in psychiatry to help them make sense of their clinical experiences in general psychiatry and develop a depth of sensitivity with their patients. A patient was presented with the problem that no one in the team felt any compassion for her and her behaviour, and this clearly affected any notion of therapeutic progress. The staff needed help to become understanding of the difficulties from the patient's angle.

Preceding the seminar, I was talking with the SHOs about the anxiety that dominates all their minds, namely the MRCPsych examination. One was left with the question, what example is the College giving the SHOs in relation to sensitivity and compassion for their ordeal?

If the SHOs pass their multiple choice, they are then sent anywhere throughout the UK and Ireland for the clinical. This clearly is an antiquated system in need of revision. There is no reason for not holding the clinicals within defined local areas e.g. London, South East England, The Midlands, Scotland, Wales, Ireland etc. At present our SHOs are being sent unnecessarily all over the place for their clinicals, for example from London to Bangor, Paisley, Aberdeen and Dublin and vice versa. They are already in a very stressed state, waiting to do their clinicals. They are then made to travel great distances to far-flung places, which may