

that those who participate in CPD are less likely to be disciplined than those who do not and that those who are in mature professional years fare better if they keep up to date with modern practice.<sup>5</sup> There is scope within the three domains (clinical, professional and academic) of the new CPD policy to cover all specialty developmental issues while retaining generic medical and psychiatric skills. These might be further reinforced through peer groups. Each of the College faculties has had the opportunity to influence the policy, but I am in agreement with O'Leary *et al* that further refinement could take place to reflect the growing need to provide specialist care. It would be my aspiration that the CPD policy be more electronically based rather than being set in a publication which sits on the shelf for the next 5 years or more without being updated. I would welcome members' input into how this might be achieved annually, with revision of policy that is in line with their practice.

#### Declaration of interest

J.S.B. chairs the Royal College of Psychiatrists' CPD Committee.

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#### Routine outcome measures in liaison psychiatry

Jacobs & Moran,<sup>1</sup> in their article enthusiastically supportive of the use of Health of the Nation Outcome Scales (HoNOS) as a routine outcome measure, recommend 'mild coercion' by trust managers to improve completion rates. They acknowledge the bluntness of the instrument and its inappropriateness in some specialist services but fail to consider that it may be totally inapplicable in some psychiatric specialties, one of which is liaison psychiatry.

The authors state the truism that for HoNOS to be considered an outcome measure, there need to be paired ratings. Liaison psychiatry services see patients mainly in emergency departments (A&E) and in-patient medical units. The A&E assessments are mainly one-off assessments where paired assessments are inapplicable. The average stay for acute care in the UK is about 6 days;<sup>2</sup> thus there are few patients on medical wards where paired ratings with a space of at least 2 weeks between them are possible.

Another problem in using HoNOS as an outcome measure, even in the few cases where it may be possible, is the nature of consultation–liaison work. The consultations are often directed at the referring medical team, examples including clarifying a complex capacity situation or advising on change in psychopharmacology in patients with organ

impairment. Even when the consultation is patient-focused the interventions are not necessarily aimed at bringing about symptomatic change in a short period of time. Thus, HoNOS would at best fail to capture relevant outcomes and at worst seriously misrepresent the effectiveness of liaison psychiatry teams.

This is not to say that outcome measures are not important in liaison psychiatry but they need to be smarter. Operational definitions for consultation outcomes that focus on the effectiveness of individual consultations should be agreed – such an approach has been recently studied by a Brazilian group.<sup>3</sup> Quality of liaison psychiatry services should be judged by looking at consultation outcomes and performance standards such as those recently published by the Psychiatric Liaison Accreditation Network.<sup>4</sup>

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#### Women in academic psychiatry: view from India

Dutta *et al*<sup>1</sup> discuss various reasons for underrepresentation of women psychiatrists in senior positions across academic medicine from high-income countries. We would like to share our experience from India as a representative of low-income countries.

Over the past few decades, the number of women psychiatrists in India has been on the rise and they constitute about 15% of the total number of psychiatrists. However, most of them work in junior positions, with only about 10% in senior positions.<sup>2</sup> The women psychiatrists in India are represented in different health sectors such as general hospital psychiatric units, psychiatric hospitals and the office-based practice. The majority of the premier medical schools of the country have women faculty but mostly in junior positions. Some also head academic departments in different parts of the country, and a few have headed a medical school in the past. Some of the women psychiatrists in the country have also taken leadership roles in areas of child psychiatry, suicide prevention, community psychiatry, rehabilitation of patients with schizophrenia and issues related to women's mental health. A few have held the position of the President of the Indian Psychiatric Society, the national body of psychiatrists. Although the *Indian Journal of Psychiatry*, the official journal of the Society, has never had a woman editor, some of the journals published by the constituent zones of the national Society did have women editors. One of them, the *Journal of Mental Health and Human Behaviour*, is edited by a woman psychiatrist. Critically seen as a whole, the original articles and some case reports make the

major chunk of women's contributions to the *Indian Journal of Psychiatry*. Reviews, invited articles, presidential addresses, editorials, commentaries, orations and critiques by women authors in the journal are negligible.

No woman psychiatrist acts as advisor to the Government of India on policy matters related to mental health in general or in relation to women.<sup>3</sup>

As far as looking after the specific needs related to their family-related roles, there are no guidelines for pregnancy and maternity leave for women postgraduate students in the country. If a woman joins a government job, there is a provision for maternity leave, but this often is not available for postgraduate students. Few hospitals or medical colleges provide reliable on-site day care and school-based childcare is not available when children are older. On discontinuation of a job for family building or other reasons, options for career revival after a certain period are presently unavailable because of age restrictions.

There is no association of women psychiatrists at regional or national level.<sup>2</sup> Unlike high-income countries, where specific needs, aspirations, areas of interest, monetary incentives, working styles, characteristics and other issues related to women psychiatrists have been studied and attempts have been made to address these, there is negligible research in this area in low-income countries. Moreover, women have a negligible role in policy-making in psychiatry.

Currently, there is no system addressing the specific issues related to women doctors as a whole in India and other neighbouring countries on the Indian subcontinent.<sup>2</sup>

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### Is the assessed capacity increased with the seriousness of what is at stake?

In *Re T*<sup>1,2</sup> the Court of Appeal had to consider the case of an adult Jehovah's Witness who refused treatment. A pregnant woman was involved in a car accident and, after speaking with her mother, signed a form of refusal of blood transfusion. After the delivery of a stillborn baby, her condition deteriorated, therefore a Court order was obtained in order to legalise a blood transfusion on the grounds that it was in the woman's best interest. In this case the Court of Appeal addressed the question related to capacity, life-threatening situation and right to refuse a medical treatment, particularly in relation to the degree of risk involved in a particular decision: 'What matters is that the doctor should consider whether at that time he had a capacity which was commensurate with the gravity of the decision. The more serious the decision, the greater the capacity required.' It is interesting to consider, as pointed out by Buchanan,<sup>3</sup> 'What principles then govern the practice, described in *Re T*, whereby the level of capacity required for competence rises in proportion to what is at stake?' In other

terms, is the assessed capacity required for legal competence increased with the seriousness of what is at stake? Perhaps the assessment of capacity has to consider the importance, the risk and the gravity of the decision that the patient has to make. Following this train of thought, maybe different standards of competence are needed in order to ensure that genuine choices are being made.

Buchanan & Brock<sup>4</sup> were more inclined to sustain this view in terms of capacity, whereas Culvert & Gert<sup>5</sup> and Wicclair<sup>6</sup> found the idea of different standards of competence more paternalistic-oriented. Culvert & Gert argued that the capacity related to the degree of risk was against the principle of 'symmetrical competence' and pointed out that the change of external risk can potentially change the status of a person from competent to incompetent, 'a fact inconsistent with the idea that competence is a genuine attribute of a person'.

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### Inconsistencies in Section 136 assessments

Liz Tate<sup>1</sup> rightfully mentioned that there are junior trainees attending to the Section 136 assessments, despite clear guidance in the Mental Health Act Code of Practice that it should be done by Section 12(2)-approved doctors. Further to that, the Code states that a reason should be documented for divulging from the aforementioned practice. In most places this practice of assessments by a non-Section 12(2)-approved doctor is a protocol and a norm.

Every directorate and trust has its own local policies, keeping the Code of Practice as standard. For the formulation of a local policy, representatives from multiple agencies such as police, accident and emergency departments, ambulance services, Social Services and mental health services formulate guidelines for the fluidity of the process of Section 136 assessments. Timescales are set for the completion of these assessments and are regularly reviewed.

There are provisions for middle tier or consultant cover to facilitate the Section 136 assessments. Despite these arrangements, there are units where the attendance of non-Section 12(2)-approved doctors is the first port of call for such assessment; after a detailed history has been taken from the patient, the Section 12(2)-approved doctor is contacted and the assessment completed. Furthermore, it is known that there are places where non-Section 12(2)-approved doctors discharge patients after having discussions over the telephone with a Section 12(2)-approved doctor. It has also been found