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year we switched to the alternative agent propofol, and very quickly found the expected trends emerging – on average patients have shorter fits, fewer have 'adequate' fits (according to either the motor fit or the electroencephalogram), and in consequence higher stimulus charges were being used as well as routine caffeine augmentation and hyperventilation. Unsurprisingly, our local clinical teams soon began commenting on the increase in the post-ECT confusion.

We have, therefore, begun using thiopentone for those patients who have an unacceptably high seizure threshold with propofol. We have found that thiopentone appears to have noticeably less anticonvulsant effect so that relatively lower charges and longer fits are possible – in one case a 90% reduction in charge was achieved.

Interestingly, with propofol, a number of patients are responding well even though their fit duration does not meet the usual criteria for 'adequacy' in line with the observations on monitoring seizure activity in the College's *ECT Handbook* (1995).

We would, therefore, suggest keeping the dose as low as possible if using propofol, to minimise its anticonvulsant effect. If the patient is having short fits it may not be necessary to significantly increase the charge, if feedback from the clinical team indicates the patient is responding well anyway. Thiopentone may be an acceptable alternative for those patients who cannot be given effective treatment using propofol.

A comparison of the last 23 courses of ECT using methohexitone alone with the first 20 not using methohexitone showed 13/23 'unequivocally good' outcomes in the methohexitone group versus 17/20 in the non-methohexitone group, a non-significant trend in favour of 'non-methohexitone' ($0.10 > P > 0.05$ using χ^2 with Yates correction).

Thus, the administration of effective ECT is possible without the use of methohexitone.

Reference

ROYAL COLLEGE OF PSYCHIATRISTS (1995) *The ECT Handbook. The Second Report of the Royal College of Psychiatrists Special Committee on ECT.* Council Report CR39. London: Royal College of Psychiatrists.

Chris Aldridge, Consultant Psychiatrist, **Mandy Assin**, Senior Registrar, **Safwat Elyas**, Honorary Senior House Officer, Brighton General Hospital, Elm Grove, Brighton BN2 3EW

Specialist registrars and responsible medical officer status

Sir: The Mental Health Act 1983 defines certain duties as being the sole remit of the responsible medical officer (RMO). These include the ability to discharge a section; power to bar discharge of a detained patient by the nearest relative; the granting of Section 17 leave; authorisation of consent to treatment and formulation of aftercare under Section 117 of the Act. The RMO, in relation to a detained patient is "the registered medical practitioner in charge of the treatment of the patient" (Mental Health Act 1983, Section 34(1)). The term 'in charge' is defined in the 1998 Memorandum as meaning "not responsible or accountable for the patients treatment to any other doctor". In the absence of the RMO, such duties are delegated to the acting RMO – usually another consultant covering their colleague's duties.

Can the RMO delegate such tasks to his or her specialist registrar (SpR) during leave of absence? In practice it would appear not, as is the case at present in our trust. However, we argue that delegation should be adopted as best practice. The SpR is a senior psychiatric trainee, is member of the Royal College of Psychiatrists (having passed the Membership Exam) and is likely to have a better knowledge of the RMO's patients than a consultant colleague nominally deputising. Furthermore, should not a SpR be able to practise, under supervised conditions, the skills of the RMO, the role for which they are training? Indeed, if a SpR covers as a locum consultant, they exercise full RMO powers. It is difficult in our view to understand how training to become a consultant could be considered complete without supervised experience of working with the complexities of the Mental Health Act.

There is support for our proposal in the relevant literature. Jones (1996) discusses the role of the RMO and notes that the medical practitioner need not necessarily have consultant status. The Mental Health Act Memorandum (1998) states that a SpR approved under Section 12(2) can exercise the role of the RMO when the patient's usual doctor is not available and swift action under the Act is required. The new Code of Practice (1999) names the Specialist Registrar as one of those able to grant Section 17 leave in the absence of the RMO, if they are at the time "the doctor in charge of the patient's treatment" (Section 20.3). Indeed, being the doctor 'in charge' of detained patient's treatment at a given time appears to be the key determinant in defining RMO status.

To conclude, we propose that in the absence of a consultant it should be accepted practice that the SpR may practise, under supervised conditions, utilising all the powers allocated by Section 12(2) status and exercising full responsibilities vested in the RMO role. We refer specifically to four areas:

(a) Granting of Section 17 leave.
(b) Review of consent to treatment under section.
(c) Discharge of sections, with aftercare planning under Section 117.
(d) Attendance at mental health review tribunals or hospital manager review meetings, to review the section.

We argue that new mental health legislation or guidance should encourage such practice.

References

DEPARTMENT OF HEALTH (1998) *Memorandum on Parts I to VI, VIII and X of the Mental Health Act, 1983.* London: The Stationery Office.

— & WELSH OFFICE (1999) *Mental Health Act 1983, Code of Practice.* London: The Stationery Office.

JONES, R. (1996) *Mental Health Act Manual* (5th edn). London: Sweet & Maxwell.

K. Williams, Specialist Registrar, **R. Macpherson**, Consultant Psychiatrist, Severn NHS Trust, Wotton Lawn, Horton Road, Gloucester GL1 3WL

Retention of psychiatric trainees

Sir: I was delighted to read Sally Pidd's review regarding the College census and plans to establish an integrated database allowing production of statistics regarding career pathways of psychiatric trainees (*Psychiatric Bulletin*, October 1999, **23**, 630–633).

I am interested in the retention of junior psychiatry trainees in the speciality and, anecdotally, have been aware throughout my training of the ease with which many good trainees have left without the opportunity to tell their stories. I recently attempted to set up an audit project to identify how many basic level trainees in one teaching hospital scheme went on to pursue psychiatric careers, what became of those who did not and importantly identify the reasons given for leaving using a design method similar to that described by Harvey *et al* (1998).

Using medical staffing lists I was able to identify that 59% (27/45) of new recruits to the scheme over the years 1988–1990 were members of the Royal College of Psychiatrists 10 years later. Medical staffing lists are destroyed after 10 years and I was, therefore, unable to trace back any further than 1988. Unfortunately, no information was kept on individual doctors other than an initial and surname. It was evident that these handwritten lists were incomplete and inaccurate and made identifying and therefore tracing doctors who had left impossible.

I applaud the College's efforts to collate this type of information and would hope that individual schemes could be involved in auditing their retention of trainees. I

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suspect that the drop-out rates decrease exponentially throughout training and would welcome efforts to monitor why trainees leave before attempting MRCPsych Part I.

Unless we answer these questions quickly we all continue to face the prospect of working in understaffed departments in the future.

Reference

HARVEY, J., DAVISON, H., WINSLAND, J., *et al* (1998) *Don't Waste Doctors – A Report on Wastage, Recruitment and Retention of Doctors in the North West*. NHS Executive.

Kate E. Lovett, Specialist Registrar in General Adult Psychiatry, Wonford House Hospital, Exeter EX2 5AF

Flexible training in psychiatry

Sir: Three recent papers highlighted issues relating to flexible training (*Psychiatric Bulletin*, October 1999, **23**, 610–612, 613–615, 616–618). The term 'flexible training' implies flexibility, which does not exist, although colleagues may assume it does. Timetables and posts are agreed with the College to ensure that training is equivalent to that undertaken by full-time trainees. Flexible trainees are comparable in calibre and undertake comparable training to full-time trainees (*Psychiatric Bulletin*, October 1999, **23**, 616–618). They have considerable experience, both medical and non-medical, which they bring to their work. Despite this there is a perception that flexible trainees have lower status than full-time trainees.

Most flexible trainees are female and have domestic commitments. Those regarding flexible training as inadequate are mainly male. Is this perceived lower status simply a result of the gender difference? Another explanation may lie in "the machismo of medicine" (Dinniss, 1999). Within medicine, difficult working conditions, long hours and traumatic situations are expected and dealt with by machismo rather than other coping strategies. Doctors who work fewer hours are not subjecting themselves to the same quantity of this burden as their full-time colleagues and so are not regarded as equal to them.

Flexible training is in reality part-time training, that is less work for less money, taking longer to complete. This training is no more flexible than full-time training. A change in the terminology to part-time training would remove some of the myths that surround flexible training.

Reference

DINNISS, S. (1999) The machismo of medicine. *British Medical Journal*, **319**, 929.

Helen Baxter, Flexible Senior Registrar, Nottingham Healthcare NHS Trust, Duncan Macmillan House, Porchester Road, Nottingham NG3 6AA

the college

The Royal College of Psychiatrists Winter Business Meeting

4.30 pm, 31 January 2000, to be held at the Royal College of Psychiatrists. The President, Professor John Cox, in the Chair

1. To approve the minutes of the previous Winter Meeting held at the Royal College of Psychiatrists on 3 February 1999.
2. Obituaries.
3. Election of Honorary Fellows.

The Right Honourable Sir Stephen Brown, PC

Sir Stephen Brown is the most distinguished family judge of our generation. He has, by initiating and seeing through a 'wind of change' in liaison between psychiatry and family law, established himself as our foremost reforming judge in cases with a mental health component. His unique contribution has been the humane understanding of litigants, particularly when deciding on dilemmas, of patients in a persistent vegetative state or in complex dysfunctional family cases, and in those having an international dimension. By example, Sir Stephen has realised his vision of 'working together' by medicine and the law which has greatly improved the informed wisdom of the courts' decision-making. As President of the Family Division since 1988, Sir Stephen initiated a sea-change in the standing of family law, and he has only recently demitted this important office. Innovations which he spearheaded have been consolidated, and by his example of openness and accessibility, the culture of all lawyers, doctors and other professionals who come into contact with family law, has become a model of interdisciplinary good practice admired by lawyers internationally. Sir Stephen's leadership, influence and encouragement to lawyers and doctors (especially psychiatrists) have increased evidence-based decision-making, fostered research and led to high quality training for all levels of the judiciary. This pivotal contribution from one of our most eminent judges has secured interdisciplinary cooperation between lawyers and mental health professionals as an established part of legal decision-making.

Dr Robert Kendell, CBE

Bob Kendell has just ended his term of office as President of the Royal College of Psychiatrists. His presidency has been the culmination of a distinguished academic career, combining intellectual brilliance, teaching skills – which have clarified areas of psychiatry for trainees over the last 30 years – and astute managerial skills in organising the College and its Committees. He graduated from Peterhouse College, Cambridge, followed by King's College Hospital Medical School obtaining academic distinction in Natural Sciences and Surgery and went on to achieve a distinction in the DPM, followed by the Gaskell Gold Medal in 1967. Thereafter, he worked at the Institute of Psychiatry and University of Vermont, before taking up his post as Professor of Psychiatry at the University of Edinburgh in 1974. He was Dean of the Medical Faculty from 1986–1990. During his term in Edinburgh he became an international expert on psychiatric epidemiology in relation particularly to diagnosis and classification of schizophrenia, affective disorders and post-natal psychiatric illness. He has written almost 100 papers and chapters in books, as well as being co-author of the *Companion to Psychiatric Studies* (Johnstone *et al*, 1998), which has become something of a bible for trainee psychiatrists. Following a spell as Chief Medical Officer in Scotland, during a time when there were many and difficult changes in the NHS, he returned to psychiatry to become President of the Royal College. His presidency will be remembered for his incisive intellect that has allowed him to successfully challenge politicians and administrators, particularly in the field of Mental Health legislation. In

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