Medical training in Australia

DEAR SIRS

I read with interest Dr Balmer's article on the benefits of experience in a general practice attachment during his psychiatry training. (*Psychiatric Bulletin*, July 1993, **17**, 422–423). Having recently returned from Australia, where I completed the examination for FRANZCP, I would like to comment on my experience of medical training within the Australian system.

The clinical component of the examination for membership for the RANZCP includes a medical viva. This is designed to test a candidates knowledge of general medicine as applied to psychiatry. Currently, candidates interview and examine one medical patient and are subsequently examined by both a physician and a psychiatrist.

In order to prepare for this somewhat daunting task most candidates organise some general medical tuition. I attended a weekly out-patient clinic with a physician who conducted a general medical clinic and had an interest in teaching. During this time I was updated on current medical thinking and treatments, refreshed my clinical skills and was coached in exam technique. Through contact with medical registrars in training I was also directed toward ward based patients who illustrated various clinical signs and symptoms.

This exchange of ideas in teaching was not, I feel, entirely one way. As an experienced psychiatrist I was also able to comment on psychiatric aspects of patients' presentations, where appropriate, without having any formal clinical involvement.

I was struck by a number of benefits at the re-exposure to hospital medicine after, in my case, nearly ten years in psychiatry positions. First, it serves as an educational role in both acquiring new knowledge (particularly regarding ever changing drug therapies) and in maintaining previously learned clinical skills. Second, it allows psychiatrists an awareness of the facilities available and the pressures under which our medical colleagues work. Third, it facilitates more direct communication between psychiatrists and physicians. These factors may be particularly beneficial to clinicians working away from their DGH.

As psychiatrists we have to find a balance between pursuing our area of specialty and keeping abreast of development in medical management of our patients. Opportunities for medical exposure clearly occur in liaison positions. Continuing education may also be facilitated by regular links with our medical colleagues through out-patient clinics, particularly for those psychiatrists or trainees isolated from their DGH. In my experience this is of benefit to all parties.

IAN HAYES

Central Hospital
Warwick CV35 7EE

Who acts as the consultant's nominated deputy?

DEAR SIRS

I have followed the debate on the subject of the consultant's nominated deputy with interest (*Psychiatric Bulletin*, 1992, **16**, 756–761). Cooper and Harper (*Psychiatric Bulletin*, July 1993, **17**, 439–440) question who should act as the consultant's deputy when Section 5(2) is employed by non-psychiatrists. An answer can be found in paragraph 8.14 of the Mental Health Act Code of Practice (1990), in which it is recommended that "only registered medical practitioners who are consultant psychiatrists should nominate deputies". This means that when a Section 5(2) is applied on a medical or surgical ward, it is the responsibility and duty of the consultant physician or surgeon to complete the relevant forms.

It seems unlikely that our medical and surgical colleagues are aware of their responsibilities under the Mental Health Act. Here in Northallerton, we have embarked upon an exercise to bring these to their attention, and to offer appropriate instruction.

G. E. P. VINCENTI

Friarage Hospital
Northallerton
North Yorkshire DL6 1JG

Reference

HMSO (1990) *Code of Practice, Laid before Parliament pursuant to Section 118(4) of the Mental Health Act 1983.*

Seating patients during consultations

DEAR SIRS

A good interview is important to establish rapport and gather all requisite information sensitively. It is generally considered that, in a conventional interview room, the patient should be seated at an angle to the doctor four or five feet away at the side of, rather than across the desk. This is said to facilitate eye contact and reduce the barrier between doctor and patient (Martin *et al*, 1985; Myerscough, 1989).

We wish to report a study on the preference of patients for where they sit in a general psychiatry out-patient clinic. For a five week period the consulting rooms were rearranged. The psychiatrist sat behind a desk and two identical chairs were placed equidistant from him or her and the door. One was across the desk and the other next to it. All patients were invited in as usual but given no indication of where they should sit. We recorded where they sat and whether it was their first attendance. The patients had a variety of diagnoses and were aged 16 or over. We did not examine the relationship between diagnosis and seating.

Of 91 patients, 66 (73%) sat opposite the psychiatrist and 25 (27%) to the side. There was no statistical difference between first and other attenders. Thus the majority of patients sat opposite the psychiatrist across a desk. Although the study measured seating behaviour rather than patient preference, individual patients later suggested they preferred to have a desk between them and the doctor as this made them feel more comfortable.

In view of these findings we question the "received wisdom" that patients should not be interviewed across a desk.

ALFRED C. WHITE
Queen Elizabeth Psychiatric Hospital
Birmingham B15 2QZ

MONICA DOSHI
Highcroft Hospital
Birmingham B23 6AX

R. N. CHITHIRAMOHAN
Hollymoor Hospital
Birmingham B31 5EX

JUDITH NICHOLLS
Hollymoor Hospital
Birmingham B31 5EX

References

MARTIN, P. *et al* (1985) *Towards Better Practice*. Churchill Livingstone. Pp 189–190.

MYERSCOUGH, P. R. (1989) *Talking with Patients. A Basic Clinical Skill*. Oxford University Press. Pp 14–15.

Advocacy services

DEAR SIRS

The introduction of an advocacy service in our local long-stay hospital is causing what can at best be described as teething problems. At worst it is taking psychiatric rehabilitation back half a century.

We had naively assumed that the advocacy service would confine themselves to representing the patients' views about alternative placements to hospital. However, it seems that advocates see their role as much wider. After meeting with the advocate our patients are refusing to cooperate with even the most basic of daily living activities. They now spend their days lying on their beds or sitting in easy chairs saying they do not have to do anything "because the advocacy person told them they didn't". We are having to stand by helpless while these patients lose their hard-won basic daily living skills and choose instead to pursue the non-deliberate self-harm which being in hospital is intended to prevent. Everything learnt from the decades of post-war research on institutionalisation seems wasted.

The greatest concern arises with the small minority of patients who are detained long-term under a renewed Section 3 of the Mental Health Act, 1983. As Responsible Medical Officer, I feel I have a burden of responsibility to ensure these patients receive the treatment necessary for their health. My treatment is vetted regularly by the Mental Health Act Commission and by Mental Health Review Tribunals. Yet a lay person with neither training nor vetting has equal and opposite power to sabotage my recommended treatment. Further, this person has no responsibility for the outcome.

I wonder if others are having similar experiences and whether they have any helpful suggestions?

ANTHONY WHITE
County Hospital
Durham DH1 4ST

Length of stay: a more meaningful approach?

DEAR SIRS

A problem of current bed usage statistics is that large psychiatric hospitals provide a number of distinct types of service: admission, respite, rehabilitation and long-stay. Each of these occupies beds for different lengths of time. Glover *et al* (1990) showed that analysis of percentiles of length of stay after admission can be used to separate out the acute component of care. However, the method remains retrospective. We report here the results obtained using a new method to analyse the in-patient population of a large psychiatric hospital. The method was developed to model the patient flow in the St George's Department of Geriatric Medicine in conjunction with academic mathematicians. It produces a mathematical model of the current in-patient population and hence provides up to the minute information which relates to the current bedstate and can be used to make predictions about the future.

The duration of stay since admission is analysed using the BOMPS (Bed Occupancy Management and Planning System) software package. The date of admission, date of birth and ward of residence of all in-patients is obtained from a midnight bed return provided in ASCII code by the Patient Administration Office. The software determines the best fit, demonstrates the relation between curve and data and calculates the overall length of stay and the two compartmental statistics. The results can then be produced graphically and numerically.

Analysis of the pattern of bed occupancy in one psychiatric hospital indicates that the method can be used to separate out distinct components of a hospital's work, i.e. to produce statistics relating to the average length of stay of two groups of patients, a short-stay and a long-stay group. Analysis of 469 in-patients in Goodmayes Hospital showed two groups of patients, one representing the adult unit, the other the elderly unit. The acute adult unit had 67