# the columns

# correspondence

## Details update form and the Data Protection Act 1998

I have had some difficulties with completing this recent request from the College.

If I read the consent form that they have sent me correctly, it appears to ask for my permission for the College to publish 'in the reasonable opinion of the College' my personal details held by them. This is information offered by me for the purpose of maintaining my membership, which would henceforth be available to everyone with an Internet connection worldwide. In addition, it is to be made available for use in future unspecified research, statistical analysis, and for use in what are mysteriously termed 'related activities'.

All this is stated as being for furtherance of the 'College's objectives', and relates to any information that I have supplied or will supply (with the possible exception of my ethnicity or 'home contact details'), without limit of time. No reference is made to the benefits for members – and I am unable to identify any.

The College further state that as many people should agree to this as possible because . . .

> '. . . we would then need to check, every time we make one of those 400 monthly updates, that your name in particular isn't there. If we can get agreement from *pretty much everybody* it will speed things up enormously.' (my italics).

This indicates that the College does not expect members to be able to keep up with the number of updates to the information made available as individuals. The College will be the only people who are fully aware of what they are putting out. This is a huge (and possibly expensive) risk area.

I am unhappy consenting for my information to be used for unspecified research at some time in the future. I am also unhappy that the College is requesting my consent for them to be sole arbiters of what references to me are to be made on their international and up-to-date website. I have an active interest in information management and technology and some understanding of the inherent risks.

Essentially, I believe that the degree of consent being requested would be unenforceable in the event of litigation. I am concerned that the College may feel 'safer' having asked so many different consents with only one signature requested. I believe this may be an illusion of safety, and that individual members perhaps have not fully considered how much 'consent' is required.

The final paragraph of the consent form is punctuated with the graphic of an open padlock. Maybe there is still time?

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### Reply from the College

The Data Protection Act 1998 has proven to be somewhat of a headache for us. It prevents us from posting personal information – even just a person's name – on the website without their written permission. Since we make 400 or so updates or uploads to the website each month, the bureaucracy involved in getting specific signed forms from every person mentioned in those pages was phenomenal, and was becoming a serious impediment to keeping the site going at all. The generic consent form is our way of trying to ensure that on the one hand we comply with the Act, and on the other we keep the site usable.

The wording and the approach have been approved by the College's solicitors.

It is our policy to keep personal data on the website to a minimum, regardless of what permissions we hold. Home addresses and details about ethnicity are specifically excluded, and will never be posted without a request from the person concerned. We would of course remove any details on request, if any member is unhappy with the use we make of the permission.

The benefit for members is straightforward: information can be placed on the website when it is needed, without several weeks' delay for permission requests to be sent out, reminders to be sent, text to be re-edited when we can't get hold of people, and so on. The website staff can get on with developing the site, rather than spending most of their time bothering members for permissions, which in most cases seem trivial to the people concerned. By way of example, we are now able to generate committee lists for Faculties, Divisions, etc. directly from the College's database, and we have a routine to automatically filter out those people who haven't signed the generic consent.

The form offers a specific opt-out for use of the data in research, analysis and other uses, and members are welcome to make use of this opt-out if they wish. Our main concern is simply to be able to make the website work.

The system is now working well. We have received consent from 7700 members, and this has reduced the administrative overhead considerably. We would like to reduce it still further, and we would encourage any members who have not yet signed their form to do so. An FAQ giving further information is available at http://www.rcpsych.ac.uk/dpa.

**Dave Jago** Head of Publications, The Royal College of Psychiatrists

## Flexibility is the key word

I have followed with interest the debate on the changing role of the consultant psychiatrist, and the difficulties in recruitment and retention. Over the past 6 months, there have been editorials, opinion articles, correspondence and a recent study by Mears *et al* (*Psychiatric Bulletin*, April 2004, **28**, 13–131) about different aspects of this debate. The Royal College, the British Medical Association and the General Medical Council are all debating how to reflect these pressures by changing consultant roles. I agree with Professor Appleby that flexibility is the key word (*Psychiatric Bulletin*, April 2004, **28**, 113).

As a specialist registrar, I have watched consultants and trusts struggle to provide safe, effective services within constrained budgets. Compared with a training post, a substantive post brings with it not just increased clinical work and responsibility, but also extra roles in management and



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columns

teaching. On top of this, individuals have to fit in a healthy work–life balance.

During training, I decided that sectorised jobs involved too many competing demands. I opted to work only with in-patients as a part-time consultant. Unfortunately, many trusts that I approached for jobs struggled to accommodate this style of working.

I have been able to take advantage of an opportunity offered by National Health Service professionals. I started in February on the New Consultant Entry Scheme, which offers a 6 month trial with support, mentoring and extra continuing professional development time. There have been teething problems but the chance to try out newer ways of working on a trial basis seemed less risky than committing to a substantive job only to walk away.

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## Melatonin use in children

Armour & Patton write a helpful review on the use of Melatonin in children (*Psychiatric Bulletin*, June 2004, **28**, 222–224). Several studies they mentioned were with blind subjects. It is important to consider that blind people have free-running circadian rhythms that are not amenable to the most powerful of resetting cues – light. The use of melatonin to trigger the new 24-hour period is very powerful in this population (Sack *et al*, 2000).

Lewy *et al* (2002) showed that low levels of melatonin, 0.5 mg, reset rhythm but not high doses, 2 mg. The prolonged half-life of melatonin and the sensitivity of the circadian rhythm to its presence mean that in trying to achieve phase advancement (bringing sleep forward to combat 'sundowning' in the elderly) or delay (delaying sleep onset to combat 'jetlag') melatonin has a window effect. Too low a dose and no effect, too high and the chronobiologic effects are lost and the direct somnolent action is experienced. It would be a shame if a potentially useful treatment for circadian rhythm disorders, including sleep disturbances and seasonal affective disorders, were discarded prematurely due to a perceived lack of efficacy.

### Declaration of interest

The author uses melatonin to reduce recovery time from intercontinental jetlag: personal use only.

LEWY, A. J., EMENS, J. S., SACK, R. L., *et al* (2002) Low, but not high, doses of melatonin entrained a free-running blind person with long circadian period. *Chronobiology International*, **19**, 649–658.

SACK, R. L., BRANDES, R. W., KENDALL, A. R., *et al* (2000) Entrainment of free-running circadian rhythms by melatonin in blind people. *New England Journal of Medicine*, **343**, 1070–1077.

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## Copying letters to patients

Dr Hughes raises an important issue which would be of concern to most psychiatrists (*Psychiatric Bulletin* (Correspondence), May 2004, **28**, 183). In addition to changing the letters to patients, I wondered if patients opting to receive them belonged, predominantly, to a specific diagnostic group.

I therefore obtained a list of 100 patients who had indicated a choice of whether to receive these letters. The uptake was 76%, which was higher than we expected and their diagnoses were spread out across most diagnostic categories. The majority belonged to the depressive disorder and the neurotic and stress related categories. A higher uptake might have been because other staff members rather than doctors or community psychiatric nurses (associated with poorer uptake) handed out opt-in forms.

A pilot study showed 83% of patients wanted to continue to receive these letters though 18% initially found them to be distressing (Harpal Nandhara *et al*, *Psychiatric Bulletin*, February 2004, **28**, 40–42). An appropriate selection of patients to possibly exclude the latter group is thus crucial. Patients who lack capacity and those who present some risk may be considered not suitable to receive these letters (Dale *et al*, 2003). I now make patients more aware of what is actually written down in their case-notes in the course of the consultation. This hopefully reduces any future surprises when they eventually receive a copy of the letter.

This initiative may alter the relationship between psychiatrists and their patients and thus necessitate a review of this process in future. I will re-survey this group in future to ascertain if their wishes to receive these letters change.

DALE, J., *et al* (2003) Copying letters to patients. *BMJ*, **327**, 450–451.

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## Cannabis reclassification

On 29 January 2004, cannabis was reclassified using the groupings of the Misuse of Drugs Act 1971 from Class B to Class C. As well as the increasing evidence that the drug is harmful to both physical and mental health, which has been recently highlighted (Henry *et al*, 2003; Rey & Tennent, 2002) this has caused confusion and concern regarding its legal position. This has been highlighted in articles on TV, broadsheet ('Cloud of confusion over cannabis', *Daily Telegraph*, 23 January 2004) and tabloid newspapers ('Pot a joke', *The Sun*, 23 January 2004).

We would like to report our deep concern that this confusion may extend to the medical student population, 5 days after the reclassification.

As part of an evaluation of a substance misuse lecture given to first year medical students at Sheffield University, 163 completed an evaluation form (62% response rate) (fig. 1). When asked if smoking cannabis at home by yourself was illegal, 42% of the responders answered incorrectly that it was not. Eighteen per cent were under the misapprehension that smoking cannabis in a public place was not an arrestable offence. Surprisingly, given the publicity, 41% did not know the drug class cannabis resin belonged to.

Further questions in the evaluation related to other drugs, their purchase and means of administration. We highlight these findings because cannabis is known to be the most widely used illegal drug among medical students (Pickard *et al*, 2000), with reports of 54% of males and 40% of females using at least once (Webb *et al*, 1998).

If this surprising level of ignorance exists in medical students, we wonder what the understanding of the rest of the population is. This is especially important given that those of a similar age to our students are most likely to use cannabis, the government's own data showing that 44% of 16–29 year-olds have used the drug (Home Office, 2000).

HOME OFFICE (2000) British Crime Survey 2000, Research, Development and Statistics Directorate. www.homeoffice.gov.uk/rds/pdfs/hcrs224.pdf.

HENRY, J. A., OLDFIELD, W. L. G. & KON, O. M. (2003) Comparing cannabis with tobacco. *BMJ*, **326**, 942–943.

PICKARD, M., *et al* (2000) Alcohol and drug use in second-year medical students at the University of Leeds. *Medical Education*, **34**, 148–150.

REY, J. M. & TENNENT, C. C. (2002) Cannabis and mental health. *BMJ*, **325**, 1183–1184.

WEBB, E., *et al* (1998) An update on British medical students' lifestyles. *Medical Education*, **32**, 325–331.

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