columns

and how they should be working and, instead of introducing flexibility, enforce rigidity. They lose person-centred holistic care by replacing skilled clinicians with tick-box policies and procedures (Drife, 2006) for people working beyond their competencies.

DRIFE, J. O. (2006) The history of box ticking. *BMJ*, **333**, 557.

GENERAL MEDICAL COUNCIL (2006) *Management for Doctors*. General Medical Council (http://www.gmc-uk.org/guidance/current/library/management_for_doctors.pdf)

SAINSBURY CENTRE FOR MENTAL HEALTH (2003) *Money for Mental Health. A Review of Public Spending on Mental Health Care*. Sainsbury Centre for Mental Health (http://www.scmh.org.uk/80256FBD004F3555/vWeb/flKHAL6TJLJ6/$file/scmh_money_for_mental_health.pdf).

Susan Mary Benbow Professor of Mental Health and Ageing, Centre for Ageing and Mental Health, Staffordshire University, Blackheath Lane, Stafford ST18 0AD, email: drsmbenbow@aol.com

doi: 10.1192/pb.32.5.195b

Assessment of mental capacity: who *can* do it, or who *should* do it?

I was interested to read about the discrepancy in the number of capacity assessments carried out by doctors on general adult and old age psychiatry wards (Singhal *et al*, *Psychiatric Bulletin*, January 2008, **32**, 17–19). Although the authors gave no explanation, the result could be because in-patients on the general adult wards, who probably lacked capacity, were more likely to be detained under the Mental Health Act and therefore fell outside the Bournewood gap.

This result does however support my belief that doctors on general adult psychiatry wards do not assess their patient's capacity (to consent to treatment) often enough.

I took part in a survey (Hill *et al*, 2006) in which consultant and trainee psychiatrists were asked, 'What are the key elements in the assessment of a patient's capacity?' Over a third of the 95 participants could only identify two or less of the five points in testing decision-making capacity (Department of Health, 2005; Re C, 1994). This suggested an inadequate level of knowledge and I believe that as doctors we could become even more de-skilled, should we rely entirely on our nursing colleagues to fulfil this role in future.

The authors make the point that, 'Appropriately trained mental health nursing staff can undertake this assessment.' I am sure they *can*, but *should* they?

I believe it is appropriate that as prescribing doctors, *we* should be assessing our patient's capacity to consent to the proposed treatment, and not merely delegate these duties to other healthcare professionals. This makes sense from an ethical and medico-legal perspective.

DEPARTMENT OF HEALTH (2005) Mental Capacity Act 2005. Department of Health.

HILL, S. A., MATHER, G. I. & JAMES, A. J. (2006) Assessing decision-making capacity: a survey of psychiatrists' knowledge. *Medicine Science and the Law*, **46**, 66–68.

Re C (Adult: Refusal of Medical Treatment) [1994] 1 AllER 819.

Schalk du Toit Specialty Registrar Year 4 in General Adult Psychiatry, National Health Service Grampian, Royal Cornhill Hospital, 26 Cornhill Road, Aberdeen AB25 2ZH, email: s_dutoit@doctors.org.uk

doi: 10.1192/pb.32.5.196

Re-examination of forensic psychiatry needs a proper examination of alternatives

Turner & Salter's re-examination of the relationship between forensic and general psychiatry was provocative and rehearsed the criticisms from generalists towards their forensic colleagues (*Psychiatric Bulletin*, January 2008, **32**, 2–6). No doubt it is important for forensic psychiatrists to consider external views in reflecting on their own practice. However, I feel it necessary to highlight the fallacy of simply adopting the US system, as was suggested by the authors. Their approach of effectively separating the treatment of offenders with mental disorders from the contribution of psychiatry to the court-room brings with it serious ethical problems which should not be overlooked. One line of thinking, as advanced by Stone (1984), argues that clinicians should not act as expert witnesses as they cannot help but use their therapeutic skills at interview which may induce disclosures used by courts for non-medical purposes. However, this raises the unedifying prospect of participants in the legal process unused to delivering psychiatric treatment being responsible for advising the court on mental health disposals. This does not seem to me in the interests of the justice or the best way to ensure treatment needs are met. An alternative view expressed by Appelbaum (1997) argues that psychiatric testimony falls outside traditional medical practice and therefore is not subject to traditional medical ethics, meaning that psychiatrists need not feel bound by medical ethics when acting as expert witnesses. However, it is difficult to see how a trained psychiatrist would not, unwittingly or otherwise, use their specialist interviewing skills in obtaining evidence from a defendant. For this reason they should be bound, at least in part, by the ethics of their profession.

In my view, the most appropriate approach to be taken in the UK was explained by O'Grady (2002), who incidentally provided the response to Turner & Salter's article (2008). O'Grady argues that forensic psychiatrists should adhere to both justice ethics (truthfulness, respect for autonomy and respect for the human rights of others) as well as medical ethics (beneficence and non-maleficence). This type of theory of 'mixed duties' was approved by the Royal College of Psychiatrists (2004). It encourages forensic psychiatrists to be highly sensitive to the ethical dilemmas inherent in their sub-specialty. I acknowledge the brief nature of Turner & Salter's article, but feel their suggestion that the problems they perceive could be resolved simply by adopting the US practice is overly simplistic and should have been accompanied by a description of the limitations of this approach.

APPELBAUM, P. S. (1997) A theory of ethics for forensic psychiatry. *Journal of the American Academy of Psychiatry and the Law*, **25**, 233–247.

ROYAL COLLEGE OF PSYCHIATRISTS (2004) *The Psychiatrist, Courts and Sentencing: the Impact of Extended Sentencing on the Ethical Framework of Forensic Psychiatry*. College Report CR 129 (http://www.rcpsych.ac.uk/publications/collegereports/cr/cr129.aspx).

O'GRADY, J. (2002) Psychiatric evidence and sentencing: ethical dilemmas. *Criminal Behaviour and Mental Health*, **12**, 179–184.

O'GRADY, J. (2008) Time to talk. Commentary on . . . Forensic psychiatry and general psychiatry. *Psychiatric Bulletin*, **32**, 6–7.

STONE, A. A. (1984) Ethical boundaries of forensic psychiatry: a view from the ivory tower. *Bulletin of the American Academy of Psychiatry and Law*, **12**, 209–219.

Andy Bickle Specialist Registrar in Forensic Psychiatry, East Midlands Centre for Forensic Mental Health, Leicester, email: Andrew.Bickle@nottshc.nhs.uk

doi: 10.1192/pb.32.5.196a

Does hyoscine need to be 'legally' prescribed?

A recent visit to the Wickham Unit (a low-secure rehabilitation unit) at Blackberry Hill Hospital, Bristol, by the Mental Health Act Commission raised a controversial issue regarding the legal prescribing of medication for individuals who are detained under the Mental Health Act. There was a case of a patient who had consented to treatment and had a Form 38 completed in accordance with Section

columns

58 of the Mental Health Act 1983, among others for clozapine. He was experiencing hypersalivation as a side-effect so was prescribed hyoscine hydrobromide. It was not thought necessary to include this on the Form 38 as hyoscine is not a psychotropic drug. The Commissioner, however, stated that the hyoscine was not authorised, meaning the medication had been unlawfully administered, and the Avon and Wiltshire Mental Health Partnership NHS Trust had to advise the patient about his right to seek legal advice.

Hyoscine appears twice in the British National Formulary, in the chapter on the central nervous system under 'Drugs used in nausea and vertigo' and in the chapter on anaesthesia under 'Antimuscarinic drugs'. Hyoscine is not classified under 'Antimuscarinic drugs used in parkinsonism'. Antimuscarinic drugs used for anaesthesia is quite distinct from 'Antimuscarinic drugs used in parkinsonism'. We do regard the latter as needing to be documented on the legal paperwork, such as precyclidine, because of an accepted recognition of good practice. Is it now the case that for any side-effect caused by psychotropic medication that is being treated by drugs, these drugs need to be listed on Forms 38/39? If so, should our patient's senna and metformin be listed as well, as the constipation and diabetes he has is likely (but of course not necessarily) to be a result of the clozapine?

BMJ PUBLISHING GROUP & RPS PUBLISHING (2007) *British National Formulary 54*. BMJ Publishing Group & RPS Publishing.

***Vichal Woochit** Specialty Registrar year 4, Wickham Unit, Blackberry Hill, Bristol BS16 1ED, email: vichal.woochit@awp.nhs.uk,
Syed Husain Consultant Forensic Psychiatrist, Wickham Unit, Blackberry Hill, Bristol

doi: 10.1192/pb.32.5.196b

New exam structure – too much too soon?

The last examinations in the 'old format' have now finished, making the editorial and commentaries on 'The long case is dead' very timely (Ashurst, 2007; Benning & Broadhurst, 2007; Tyrer, 2007). In addition, psychiatric training is undergoing significant change, particularly following the difficulties associated with Medical Training Application System, and Modernising Medical Careers.

With the move towards competency-based curricula, it is important to reassess the way that trainees are assessed. Objective Structured Clinical Examinations (OSCEs) are increasingly used to assess medical students instead of the traditional long and short cases. Long cases have been used in examinations since the 1970s and while standardisation of OSCEs is easier, each station provides only a snapshot of a candidate's performance.

Workplace-based assessments are a useful addition in the assessment of trainees' competences and will now be the main method of evaluating their ability to perform a full comprehensive clinical assessment. However, these are new tools for both trainees and supervisors and it will take time and further development before they become a reliable method of assessment.

Many trainees have prepared for one examination format only to be forced into a new system, while the transitional arrangements mean that some aspects of the curriculum will not be tested in those who have obtained Part 1 and are exempt from Paper 2. Neither of these situations is ideal. An overlap between the old and new examination formats may have allowed an easier transition to a new way of working for trainees and help avoid the significant anxiety experienced by those affected by the changes.

ASHURST, P. (2007) On listening to the patient: Commentary on . . . The long case is dead. *Psychiatric Bulletin*, **31**, 446–447.

BENNING, T. & BROADHURST, M. (2007) The long case is dead – long live the long case. Loss of the MRCPsych long case and holism in psychiatry. *Psychiatric Bulletin*, **31**, 441–443.

TYRER, S. (2007) Non mors praematura: Commentary on . . . The long case is dead. *Psychiatric Bulletin*, **31**, 447–449.

Elena Baker-Glenn Specialist Trainee Year 3, Queen's Medical Centre, Nottingham NG7 2UH, email: elenabakerglenn@yahoo.co.uk

doi: 10.1192/pb.32.5.197

Forensic psychiatry and general psychiatry: re-examining the relationship

I have heard the essence of the Turner & Salter article (*Psychiatric Bulletin*, January 2008, **32**, 2–6) before but repetition does not produce enlightenment. At root, it is an attack on a branch of medicine that the authors do not seem to approve of. That is odd: I cannot think of any other branch of medicine which attracts this kind of negativity.

As John O'Grady has explained in his reply (*Psychiatric Bulletin*, January 2008, **32**, 6–7), there are many reasons why forensic psychiatry has developed. Nevertheless, one omission from the debate so far, which is surprising in view of one of Turner's other strong interests, is history. It is easy to trace the development of forensic psychiatry from about 1814 as a response to a growing awareness of the social and psychiatric problems presented by many offenders with mental disorders. The growing specialty of psychiatry was expected to take on this important group of patients. From the earliest years of this period, until the present day, general psychiatrists have tried to resist this expectation. Personally, I think that is entirely reasonable, as such patients require special facilities and special skills. However, it is unreasonable to complain when others take up the challenge instead.

For many years there were very few who took an interest in this work and very few facilities for such patients. As pressure from general psychiatrists, prisons and mental hospitals (which gradually declined in number) increased, so did the demand for special skills. With that, overcrowding in the first forensic psychiatry hospitals, the special hospitals, also increased.

The natural professional response to this was for psychiatrists, with the unusual special interest in offenders with mental disorders, to get together to discuss matters, especially clinical matters, of mutual interest. A forensic psychiatry subcommittee of the Royal Medico-Psychological Association (the forerunner to the Royal College of Psychiatrists) was formed in 1963. This became a section of forensic psychiatry when the Royal College of Psychiatrists began in 1971, and eventually, in 1997, the Faculty of Forensic Psychiatry. The clinical meetings of this developing organisation have attracted an increasing number of College members. Any psychiatrist is welcome to attend the meetings and general psychiatrists, as Turner and Salter know well, are especially welcome. We even invite them to express their negative views in debate!

Perhaps there is a hidden agenda to all this. Speculation is usually unhelpful, so I will not indulge. Maybe I can, however, entice Trevor Turner to spell out more closely what ails him. Does he have the same allergy to other specialties, and if not, then why not? I think I can speak for the majority of members of the Forensic Psychiatry faculty when I say that they are always interested to learn new ways of working and to serve patients' interests better.

John Gunn Former Chairman, Faculty of Forensic Psychiatry, and Emeritus Professor of Forensic Psychiatry, Institute of Psychiatry, King's College London

doi: 10.1192/pb.32.5.197a

Trainees' views on service user and carer involvement in training: a perspective from the West Midlands

A survey similar to Babu *et al* (*Psychiatric Bulletin*, January 2008, **32**, 28–31) was