definition of base rates of risk in other areas is not as straightforward.[2]

The acceptance of a defined level of risk has important implications for services. As an example, if a patient is considered as being at risk of suicide, rather that the accepted risk being progressively increased as the bed availability declines, the service should have an obligation to provide a bed for those whose risk is considered greater than the acceptable level.

Other common areas where risk assessments are required are release of potentially violent individuals from hospital or prison, safety in driving, the ability to own a firearm and suitability for employment in areas where inappropriate behaviour would involve significant community risk. When these assessments are made, it is important that there is not only an understanding of their predictive value, but that there should be some idea of the relative and absolute risk considered acceptable by the community. Once this is defined, it automatically follows that an adverse result does not imply error. It is important that the community representatives, including coroners and politicians as well as the media, should be educated about this. Ultimately, a decision about acceptable risk levels must be explicitly made by the community in advance with regard to their cost/benefit ratio. *Post hoc* assessments of individual decisions are generally unhelpful.

When providing reports involving risk assessment, I always enclose a comment stating that whereas I have made my own evaluation, I would reconsider my assessment on the basis of a defined acceptable level of risk. Finally, I would not agree with Large & Nielssen that risk assessment protocols should not be used. Their importance is not that they produce a usable rating (and I would note that these are strictly ordinal rather than interval scales), but that they do document that appropriate risk factors have been considered in the clinical decisions made.

1 Large MM, Nielssen OB. Probability and loss: two sides of the risk assessment coin. *Psychiatrist* 2011; **35**: 413–8.

2 Davies GRW. Psychiatry and fitness for flying: practice, evidence and principles. *Curr Psychiatry Rev* 2010; **6**: 21–7.

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doi: 10.1192/pb.36.2.78a

Medical students and a career in psychiatry: a discussion

Sorting out the factors influencing medical students' decisions about a career in psychiatry is clearly a difficult task. The importance of overcoming the negative perceptions of the specialty is a one vital aspect that needs to be addressed,[1] but a multitude of other issues need to be considered.

1 Undergraduate medical training places great emphasis on medicine and surgery. Psychiatry, in our opinion, is not viewed as medicine because it basically forces students to relinquish those skills which take years to develop and which are so heavily emphasised in assessments, for example practical procedures and physical examination. These skills equate with being a good doctor, whereas the focus on psychosocial issues makes psychiatrists appear as less-than-real doctors.
2 Some medical schools ignore psychiatry until the later years, making it an add-on specialty rather than a core part of our thinking about what medicine really is. Some do all their psychiatry in 6 or 8 weeks in the pre-final or final years. This is really like a drop in the ocean of the 5- to 6-year course.
3 Some schools have incorporated the biopsychosocial model into every area in a so-called spiral learning model; this may change students' attitudes.
4 Liaison psychiatry, which is probably the psychiatric specialty with most overlaps and which interacts with other specialties, is noticeable by its absence in hospitals. The occasional patient with a psychiatric problem on the acute ward is often treated with little interest or enthusiasm by the medical or surgical teams. Referral is often made to psychiatry without any attempt to assess or manage the problem by the patient's team. This lack of enthusiasm definitely filters down to the students.
5 Comparing attitudes to psychiatry in different medical schools before and after the first year of exposure, as well as the length of psychiatric attachment, might be useful. The latter is important because students' exposure to specialties is often too brief. A 4-week attachment is long enough to observe a recovery from pneumonia, but not usually long enough for a depressive episode that has required hospital admission. Posting students in one psychiatric unit for the whole 6–8 weeks may be better than 1- or 2-week postings to four or five different specialist teams.
6 Students are often discouraged to be hands-on on psychiatric wards. This leads to less engagement than in, say, an accident and emergency (A&E) post where they feel valued as a doctor-to-be.
7 Approach to diagnosis is important; students are often dismayed by the overlap of symptoms across psychiatric disorders and probably even more by psychiatrists appearing to not adhere to specific criteria when making diagnoses. Often, students are told that a patient has a particular diagnosis without explaining why. Trainers could easily remedy this.
8 Furthermore, psychiatrists are fairly vocal about psychiatric disorders being ultimately incurable. Even though many physical disorders such as diabetes, hypertension, asthma and psoriasis are chronic and incurable, the physicians speak more about what they can improve than what they cannot. Focus on improving patients' quality of life and returning their ability to function is often not as obvious in psychiatry as it is in other specialties. Whereas other specialists gain a sense of achievement from tangible results and high-impact outcomes, psychiatrists deal with less clear-cut, multifactorial aetiology and less measurable outcomes.
9 An issue that students may feel uncomfortable with is that psychiatrists sometimes enforce treatments on patients against their will. This contradicts the notion of the caring profession. Having seen how appreciative patients are of the work of the other specialists, a specialty where patients hate you for acting in their best interests can be very unattractive. The Mental Health Act and the role of mental health review tribunals are often not adequately explained to students, with tribunals

https://doi.org/10.1192/pb.36.2.79 Published online by Cambridge University Press

seeming to treat psychiatrists as villains who incarcerate vulnerable patients.

10 Further, whereas most doctors are concerned about making patients better, psychiatrists seem over-preoccupied with the issue of risk rather than the idea of actually making patients better. It seems that they accept the blame when their attempts to treat patients fail, whereas no other specialty seems to hold such unscientific beliefs or take responsibility for natural outcomes of illnesses they treat. Similarly, in no other specialty are negative outcomes so widely publicised. The risk of adverse publicity discourages students from choosing psychiatry. It is more appealing to be viewed as a saver.

Overall, we might improve interest in and recruitment into psychiatry by posting medical students in psychiatry earlier in their training, offering longer postings, exposing them to specialties which interact most with medicine (e.g. old age psychiatry), giving them an opportunity to see patients on acute hospital wards and in crisis (e.g. A&E, crisis teams), and to follow-up patients into recovery.

1 Curtis-Barton MT, Eagles JM. Factors that discourage medical students from pursuing a career in psychiatry. *Psychiatrist* 2011; **35**: 425–9.

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doi: 10.1192/pb.36.2.79

Review

Mental Health: Law and Practice

Phil Fennell
Jordan Publishing, 2011, £55.00, pb, 625 pp.
ISBN 9781846612404

This book is primarily about the provisions of the Mental Health Act 1983. The Deprivation of Liberty Safeguards of the Mental Capacity Act 2005, the Human Rights Act 1998 and other legislation related to mentally disordered offenders (the insanity defence, diminished responsibility, infanticide and fitness to plead) are also discussed. The Mental Health Act is printed, in full, as an appendix (accounting for 170 of the book's 625 pages).

There are many available texts on the Mental Health Act. The Act, the Codes of Practice (two for the Mental Health Act (England and Wales), one for the Mental Capacity Act and another for the Deprivation of Liberty Safeguards) and the much underused and underrated, in my opinion, the Department of Health's *Reference Guide to the Mental Health Act 1983*, are all available online and can be downloaded for free. Does this book add anything?

Unlike some publications on the subject, this book can be read (I write here as a doctor rather than a lawyer). It is not as easy reading, for most clinicians, as the Codes of Practice but it is certainly comprehensible. Matters are dealt with by subject; what is mental disorder, deprivation of liberty, consent to treatment, powers and responsibilities of staff and so on, rather than by section. All material relevant to the subject, from the Acts, case law, the Codes and other sources, is included and discussed. This makes it much easier to gain an overview and understanding of the Act's provisions than reading the Act itself (even with legal annotations) and, for clinicians with an interest in the law, certainly adds to that which is offered by the Codes.

The author has had a long involvement with mental health law reform and acted as a special advisor to the Joint Committee of both Houses of Parliament which scrutinised the 2004 draft of the Mental Health Bill. This is evident not only from the 'background' chapter but also in the number of occasions when he describes the provisions before and after the 2008 changes and rehearses the arguments put forward at various stages in the reform process. Readers who worked with the original 1983 Act (and, indeed, the 1959 Act) or wish to understand the amendments will find this material interesting. Others, particularly those who have to use the Act, and wish to do so correctly, but whose primary interest is clinical, may just find it confusing. The chapter on defining mental disorder is a good example of this. The subject may be considered to be difficult enough without reference to terms and expressions (e.g. psychopathic disorder and the previous 'treatability' test) that are now irrelevant.

The publishers say the book is 'essential reading' for (among others) 'Tribunal Judges and mental health professionals'. For the latter group, I would say it is good, if you are interested, but not essential.

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doi: 10.1192/pb.bp.111.037085

https://doi.org/10.1192/pb.36.2.79 Published online by Cambridge University Press