the columns

correspondence

Is ECT patient-centred?

At times the balance between understanding patients' experiences of ill health and the biological models of disease processes can be difficult to achieve. Most healthcare professionals recognise the importance of both the scientific theories of disease and abnormal functioning, but also of ethical issues and the subjective experience of illness. Evidence-based medicine highlights the importance of taking into account three elements: the evidence, patient particulars and patient preference (Haynes, 2002). To ignore any one of these aspects would lead to an approach to care which cannot be patient-centred.

Professor Cawley suggested that 'psychiatry is more than a science' (Cawley, 1993), containing an 'undefined something extra' in addition to its scientific knowledge and practice. Psychiatry's concern with the uniqueness of each individual, empathy and communication with patients is 'inevitable and ever-present'.

This is especially important for patients undergoing electroconvulsive therapy (ECT), who not only face the stigma of the treatment but also the potential disempowerment of such a technique, particularly in those cases where it is carried out against the wishes of the patient. The study carried out by Kershaw *et al* (2007) was potentially able to address this issue, but unfortunately the researchers did not report whether the patients were being treated voluntarily, nor their attitudes towards ECT before receiving treatment.

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Smith & White (2007) showed it was feasible to complete HCR–20 (Historical Clinical Risk – 20-Item Scale) ratings on most patients within 48 hours of admission to their general psychiatric wards but did not demonstrate that this approach was likely to be valid or useful.

First, HCR–20 was specifically developed for forensic patients. Furthermore, the reliability of the results in some items can be poor even for trained raters (Douglas *et al*, 2003) and worse for untrained ones.

The drive behind risk assessment is to identify patients who represent a significant risk of serious violence. However, the risk of a patient with schizophrenia being convicted of serious violence is 0.2% per annum (Wallace *et al*, 1998) and Monahan (1981) has emphasised that 'if the base rate [of violence] . . . is low then even a relatively accurate predictive test risks misclassifying many non-violent people.'

Risk assessment should be reliable, valid and result in a risk management plan, and therefore it requires careful enquiry. It is wasteful and unhelpful to assess every patient admitted. Detailed assessment should be for those *a priori* representing increased risk. Professionals should screen patients for previous violence and only then carry out detailed risk assessments on those who have a history of violent behaviour and those who for other reasons give concern, for instance because of violent fantasies or threats. To assist them, professionals need to know the most important predictors of violence, in order of importance: psychopathy, previous violence, and comorbid substance misuse.

The HCR–20 is an appropriate tool for forensic patients, but the MacArthur Classification of Violence Risk (COVR) is more valid for general psychiatry. This is available with a software programme with cut-off points for high and low risk, though these need to be treated with caution in the UK population.

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Polydipsia in psychiatric patients

Chronic subdural haematoma is notorious for leading to mistakes in diagnosis (Lishman, 1978). Before the advent of computerised tomography, only a fourteenth of cases in mental hospital patients was diagnosed in life (Cole, 1978). We report a case presenting with polydipsia.

An elderly man with chronic psychosis was admitted to a medical ward with a 2-week history of polydipsia and agitation. Liaison psychiatrists transferred him to an acute psychiatry ward as a case of psychogenic polydipsia. He was found to be manic with euphoria and flight of ideas. Occasionally he also complained of headaches, had dyspraxia and became incontinent. This prompted an MRI (magnetic resonance imaging) brain scan showing bilateral chronic subdural haematomas with modest mass effect. Conservative management was tried at first. However, a fresh bleed with onset of hemiparesis led to emergency evacuation with full recovery and resolution of polydipsia.

Psychogenic polydipsia is a common occurrence amongst psychiatric in-patients (Dundas *et al*, 2007). As the underlying pathophysiology of this syndrome is unclear, comprehensive evaluation of such cases is warranted.

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The case for the long case

Having taken (F.O.) the Objective Structured Clinical Examination (OSCE) as part of the MRCPsych part I, I found that the skills acquired for the exam were less helpful in my day-to-day clinical work than presentations of cases to senior colleagues. These allowed me to have a more comprehensive grasp of the scenarios. Plans to jettison the long case will lead to a reduction in emphasis on one's ability to perform such presentations (Oyebode *et al*, 2007).

Moreover, as a trainee for whom English is a second language I fear that replacing the long case with objective structured examination will deprive people like me of the opportunity to improve our language skills.

Thus we support the case for the long case!

OYEBODE, F., GEORGE, S., MATH, V., *et al* (2007) Inter-examiner reliability of the clinical parts of MRCPsych part II examinations. *Psychiatric Bulletin*, **31**, 342–344.

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Vending machines in acute psychiatric units: what purpose do they serve?

People with mental illness are over 50% more likely to be overweight or obese than those without (Compton *et al*, 2006). Evidence shows that people with schizophrenia have an increased risk of early death, mostly due to cardiovascular disease and diabetes linked to obesity.

A case–control study carried out in Nithsdale, Scotland (McCreadie *et al*, 1998) showed that most patients with schizophrenia were overweight or obese and their intake of saturated fats was higher compared with age-matched controls. On average they consumed 12 portions of fruit and vegetables a week instead of the recommended 35 per week. It was concluded that people with schizophrenia were making poor dietary choices and assertive programmes were needed.

Patients admitted during acute phase of their mental illness often have impaired judgement; therefore care should be anything but increased in such situations. However, astonishingly many mental health units have placed vending machines outside the acute mental health wards, which only dispense chocolate bars, crisps and soft drinks, with no healthy options. It is hard not to be cynical about the motives behind installation of such machines; surely it is not just for the convenience of patients. Instead of being opportunistic, offering patients a diet rich in calories, refined starch and fat at their doorstep can in no way be justified.

Since stimulus control is an integral part of weight management, it is time to put the practice right and make healthier choices available to the already vulnerable client group. As healthcare professionals we cannot justify waiting for someone like Jamie Oliver to teach us the basic rules of a balanced diet.

COMPTON, M.T., DAUMIT, G. L. & DRUSS, B. G. (2006) Cigarette smoking and overweight/obesity among individuals with serious mental illnesses: A preventive perspective. *Harvard Review of Psychiatry*, **14**, 212–222.

McCREADIE, R., MACDONALD, E., BLACKLOCK, C., *et al* (1998) Dietary intake of schizophrenic patients in Nithsdale, Scotland: case-control study. *BMJ*, **317**, 784–785.

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MTAS fiasco: further shortlisting issues

Before the review group set up by the Department of Health (March 2007) to assess the Medical Training Application Service (MTAS) allowed for guaranteed interviews with trainees, a north London psychiatry rotation was surveyed regarding their MTAS experiences in a similar method to that of Whelan *et al* (2007).

Of the 52 trainees approached about the survey, 37 responded (71%). Of those, 32 were shortlisted (86%) by MTAS, 18 were offered one interview (49%), 8 two interviews (21%), and 3 were offered three or four interviews (8%). The ratio of applications to interviews was 2.3:1.

This group, which had been competitively selected in the past 2 or 3 years for basic psychiatric training in a popular London rotation, did better than the Whelan's sample (60%) in succeeding in being shortlisted at all. However, 19 of these London trainees (51%) were not shortlisted by MTAS for London. Conversely, 12 (66%) of the remaining 18 trainees that were shortlisted for London (an area generally assumed to be competitive) were not shortlisted elsewhere.

As regards applicants with Highly Skilled Migrant Permits, forming 3% of the total sample, 20% were not shortlisted, compared with 4 out of the total 31 (13%) with UK/EEA/Spousal visas.

Trainees' comments attest to the emotion behind the numbers:

> 'The lottery-like [shortlisting] result. . . illustrates the absurdity of this process.'
>
> 'I think it's not so much the system as the loss of 8000 jobs that is appalling.'
>
> 'Why should doctors with families . . . have to consider "less competitive geographies". . . especially as we have been appointed in open competition in the old system?'

Like Whelan's, this survey highlighted the questionable validity and reliability of the initial MTAS shortlisting process.

WHELAN, P., JARRETT, P., MEERTEN, M., *et al* (2007) MTAS fiasco: lessons for psychiatry. *Psychiatric Bulletin*, **31**, 425–427.

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