The rational alternative is to list specific problem areas in the patient's personality, giving appropriate examples. While this entails more time and effort than simply stating personality disorder (or more usually just 'p.d.'), it at least suggests a basis for treatment directed at specific areas of difficulty.

Concerning the practice of omitting personality disorder as a diagnosis from patients' notes in case they see them, it should be clear that the approach outlined above makes this unnecessary as it has much less potential to give offence. For example, if you point out to patients that they have difficulty controlling their anger, act impulsively and find it difficult to empathise with others – giving examples from their history, then they will probably agree with you and indeed may be impressed by your insight. Tell them that they are a psychopath however and you will not get the same reaction.

Dr Steadman felt confident in discharging a 'drunk' patient after reading the diagnosis personality disorder in the notes. But what confidence does such a label give us? It must be remembered that alcoholism and personality disorder are risk factors in both completed suicide and deliberate self harm, that patients with personality disorders may develop mental illnesses requiring hospital treatment, and that there is a duty of the doctor to act in the patient's best interests. Psychiatric diagnoses can also change over time.

I am sure Dr Steadman was correct to discharge his patient, but such decisions should be made on the basis of assessment at the time. Previous notes are useful as a guide to management, but past diagnoses should be treated with suspicion, and should have little bearing on decisions in the emergency situation.

ADAM KIRBY, *Southport and Formby Community Health Services NHS Trust, Hesketh Centre, 51–55 Albert Road, Southport PR9 0LT*

Training, manpower and employment in Australia

Sir: It was interesting to read Dr Kisely's article about psychiatric manpower and training in Australia (*Psychiatric Bulletin*, 1993, **17**, 669–671) from my perspective as a British psychiatry trainee currently two months into a one year exchange post in Sydney.

Dr Kisely does not state from what perspective he has written his article – whether as an Australian working in Britain or vice versa – however, I would think he has not worked in New South Wales. It is important to emphasise that there are marked differences between the six states and two territories in terms of mental health legislation service provision and arrangements for medical registration.

While Dr Kisely comments that arrangements for temporary work experience as part of training remain relatively straightforward. I found that arranging my visa and medical registration to work in Sydney time and finance consuming and, although hospitals in New South Wales may be happy to employ a British psychiatry trainee, the Immigration Department and Medical Board of NSW do not make things easy for them. The Medical Board of NSW grant "registration with conditions" when the applicant is exchanging work with an Australian psychiatric trainee or when the applicant can make a case that he or she is furthering his or her training by working in a designated post in New South Wales. When the Board have approved the position on the basis of these criteria the applicant can apply for a temporary residence visa which allows him or her to work on arrival in Australia. The applicant then has to present him or herself to the Board with documents and photographs and a cheque for $A275.00 in order to gain a registration certificate which allows him or her to work only in the post to which he or she has originally applied for, and which disallows him or her from doing any private work, working as a locum or working in any other post. It is therefore a time consuming process with a number of potential stumbling blocks.

I would encourage trainees to come and work in NSW but I would advise them to make plans well in advance and to inform themselves fully of their prospective conditions of service.

ALCUIN WILKIE, *Westmead Hospital, Westmead NSW 2145, Australia*

Case conferences: an essential part of training in psychiatry

Sir: Rowlands & Geddes (*Psychiatric Bulletin*, 1993, **17**, 363–364) emphasise the importance of journal clubs in the education of psychiatric trainees. Case conferences are a similarly important part of psychiatric training. It is recommended that such conferences take place weekly for a minimum of 30 weeks in the year (Royal College of Psychiatrists, 1987). It is therefore surprising that little attention has been paid to the subject in the psychiatric literature. Case conferences are an excellent way to learn presentation and interview skills. In addition they provide a forum for sharing knowledge and experience about the diagnosis and treatment of mental illness. Standard formats for presenting a case have been described (Vincenti, 1990; Holden, 1987). Sadly, at the

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beginning of training, a formal introduction to the techniques and skills of case presentation may not always occur. A well organised case conference can be a sociable, enjoyable and effective method of education in psychiatry. Conferences provide a forum for the multi-disciplinary discussion of clinical cases and expose the trainee to patients, ideas and opinions they might otherwise not encounter. They are also excellent preparation for the MRCPsych examination.

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J.D.D. LAIDLAW and D. ALLEN, *Oxford Regional Psychiatry Rotation, Campbell Centre, Milton Keynes Community NHS Trust, Milton Keynes MK6 5LD*

Feedback on the MRCPsych examination

Sir: It is reassuring to hear from Dr Mann that the College takes marking the MRCPsych examination so seriously, (*Psychiatric Bulletin*, 1993, **17**, 686) although this results in some delay in publication of the results. However, for those candidates who are unsuccessful, feedback on the relevant portion of the examination which they failed seems to be subject to considerable delay. In my own case, which is not exceptional, I received feedback for the Spring Exam three months after publication of the results and some three weeks before the Autumn diet. Consequently this feedback, although constructive and welcomed, is of limited utility. Why the delay, and can anything be done to expedite the feedback?

JAMES WARNER, *7 Streatham Common South, London SW16 3BT*

Outcome measures in mental health

Sir: In the current era of open access to patient notes, I would be very interested to discover psychiatrists' attitudes to the following matter.

I recently attended a conference on quality assurance at which Professor Wing of the College Research Unit spoke on outcome measures in mental health. One aspect which I did not hear addressed was whether patients would have access to the current rating given to them by a health care professional. With the recent emphasis on empowerment of patients, it could be argued that this is an essential piece of information; however it is also easy to see the potential damage this may cause in certain circumstances. I feel these issues should however be addressed before outcome measures become a compulsory part of our clinical life and that we should be pro-active in developing a policy in this area rather than as on many occasions re-active.

J. COATES, *Belfast City Hospital, Belfast BT9 7AB*

Sir: Dr Coates refers to the simple scales now being developed by the Research Unit to measure outcomes in connection with the first mental *Health of the Nation* target (DOH, 1993). If and when these become part of the patient record they will be subject, like the rest of the clinical record, to the provisions of the Access to Health Records Act 1990 (NHS-ME, 1991). College guidance on this has been published (1992). A College document on confidentiality is also relevant (1990).

In general, the issues raised by the scales are no different from those involved in the use of other clinical records. Information from carers should also, of course, be recorded, raising problems that are discussed in the Act and in the College commentary.

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NHS-ME (1991) *Access to Health Records Act 1990: A guide for the NHS*. Health Publications Unit
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Monitoring of blood pressure at a GP depot clinic

Sir: Depot neuroleptics are often initially prescribed within a specialist setting such as in-patient or day hospital units. With increasing emphasis on community care, the burden of providing depot medication and to some extent psychiatric follow-up is being transferred to the primary health care setting. The question as to whether patients with chronic mental illness receive the same amount of screening in terms of blood pressure monitoring as those who have chronic medical illnesses requires closer scrutiny.

Eighteen patients, from a GP depot clinic, were matched for age and sex using the practice computer, with patients suffering from arthritis. A retrospective case examination for five years was performed; the number of presentations and blood pressure measurements for each period was then recorded.

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