



the columns

correspondence

European Commission Green Paper on mental health

Professor Stefan Priebe (*Psychiatric Bulletin*, August 2006, **30**, 281–282) asks whether the European Commission Green Paper on mental health is a 'sign of progress or confusion'. It is a manifest sign of political progress and as such has been welcomed by the College (Royal College of Psychiatrists, 2006).

We must remember that the purpose of the Green Paper was to begin consultation for a future strategy. It is premature to expect 'achievable priorities and specific ideas', and off-the-peg solutions will not suit all member states. As first steps, a platform for exchanging expertise, greater coherence between information, research and policy, inclusion of mental health in the framework programme for research funding, and a more uniform approach to human rights seem to be realistic and valuable.

We must also understand the scope of responsibility of the European Commission, which includes health promotion, prevention and provision of information but not healthcare services. Hence the use of the broad World Health Organization terminology for 'mental ill health', and the emphasis upon a wide range of problems, many of which should not be considered as illnesses. Promotion of mental well-being necessitates collaboration between policy makers from health, economics, housing, immigration, criminal justice, employment and other departments. The aspiration is indeed to further the debate within political and commissioning circles – not to treat people who are not ill.

Priebe's reservations seem to result from confusion between the case for widespread promotion and prevention, and the specialised need for good treatment for those with established conditions. No problem!

ROYAL COLLEGE OF PSYCHIATRISTS (2006) *College Response to the European Commission Green Paper on Mental Health*. <http://www.rcpsych.ac.uk/pressparliament/collegeresponses/parliament/responses/collegeresponsemay06.aspx>

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The Hippocratic Oath: is it outdated?

Marzanski *et al* (*Psychiatric Bulletin*, September 2006, **30**, 327–329) highlight the shortcomings of the Hippocratic Oath in their survey of psychiatrists' attitudes. The Oath has become flawed for two main reasons.

First, it is outdated. It contains archaic, gender-specific language but, more importantly, it completely forbids abortion. Doctors in all regions of the UK widely support the provision of termination of pregnancy (Marie Stopes International, 1999) which is legal in Great Britain. Marzanski *et al* confirm unease with this principle of the Oath, although the standard responses on their Likert scale do not necessarily lend themselves to accurate representations of respondents' views on this and some other principles surveyed.

Second, the Oath has been superseded by adequate modern guidance and doctrine, which relate more closely to current practice and expectations of doctors. *Good Medical Practice* (General Medical Council, 2001) provides guidance to all UK doctors on issues of ethics and professionalism, and the *Declaration of Geneva* (World Medical Association, 2006) sets out 11 principles of medical practice in much the same manner as the Oath. Unlike the Oath, the *Declaration* does not mention abortion and includes pledges not to discriminate on racial, religious or other grounds and not to violate human rights or civil liberties. This latter pledge holds a special significance for our specialty, given the abuses that have been perpetrated internationally in the name of psychiatry.

GENERAL MEDICAL COUNCIL (2001) *Good Medical Practice*. <http://www.gmc-uk.org/guidance/library/GMP.pdf>

MARIE STOPES INTERNATIONAL (1999) *General Practitioners: Attitudes to Abortion*. <http://www.mariestopes.org.uk/pdf/gps-attitude-report.pdf>

WORLD MEDICAL ASSOCIATION (2006) *Declaration of Geneva*. <http://www.wma.net/e/policy/c8.htm>

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First on-call psychiatrist: resident or non-resident?

Mason *et al* (*Psychiatric Bulletin*, September 2006, **30**, 329–333) described the first on-call activity of senior house officers. We have differing views about whether the first on-call psychiatrist can function as a non-resident. Medical problems in psychiatric in-patients requiring urgent attention (such as chest pain and falls) do not always necessitate transfer of the patient to a medical/accident and emergency setting. Deciding whether to transfer a patient can be difficult without proper physical examination and relevant investigations. A resident doctor would speed up this process; any delay in such situations can compromise patient care.

There are certain clinical situations (such as agitation not responding to de-escalation) when a rapid response is necessary if patient and staff safety is not to be compromised. The effects of delay in such a situation are not easily measurable and Mason *et al* did not attempt to measure this. Hence the conclusion that 'there was no evidence that a resident doctor increased patient safety' is not justifiable.

Serious medical emergencies requiring rapid responses are thankfully rare, but equally inevitable. Such a small-scale study raises the question of a type II error.

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Monitoring the physical health of psychiatric patients on psychotropic drugs

Dr Tarrant highlights the risk of developing diabetes on antipsychotic medication and the need for monitoring of blood glucose (*Psychiatric Bulletin*, August 2006, **30**, 286–288). Psychiatric patients also tend to have a higher prevalence of other independent predictors of cardiovascular



columns

disease, including smoking, hypertension, obesity, a sedentary lifestyle and hyperlipidaemia. There is plenty of room for improvement in monitoring the physical health of patients on antipsychotic treatment.

Who should be primarily responsible for such monitoring? The American Diabetes Association and others developed a measurement consensus statement that recommended the monitoring of weight, waist measurement, blood pressure, fasting glucose and lipids (American Diabetes Association *et al*, 2004). Does the responsibility fall mainly to our primary care colleagues or do we need to take a more active role? Do we need better facilities for monitoring in our in-patient and community clinics with involvement of our nursing and dietician colleagues?

Action needs to be taken when any results or measurements are abnormal. Results are often communicated to general practitioners by letter and can easily be overlooked. I wonder whether we need to start initiating treatment such as statins ourselves. This would require ongoing education in primary care medicine. Other possible measures include interventions to promote general healthy living and lifestyle changes, and weight management clinics.

AMERICAN DIABETES ASSOCIATION *et al* (2004) Consensus development conference on antipsychotic drugs and obesity and diabetes. *Diabetes Care*, **27**, 596–601.

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Atypical antipsychotic medication is used for children and adolescents, not only for childhood schizophrenia but also for adolescents with aggressive conduct disorders (Findling *et al*, 2000) and young people who have autistic-spectrum disorders and severe aggression (RUPP Autism Network, 2002). Unlike the adult population with enduring mental illness, research into the management of these childhood disorders is in its infancy and medication is almost always used off licence. However, child and adolescent psychiatrists in the UK have become more concerned about the metabolic side-effects of atypical antipsychotic drugs in children than about involuntary movement disorders. A consensus view is emerging that children and adolescents treated with atypical antipsychotic medication should have baseline and regular blood glucose monitoring, but there are no standards to guide and audit practice. To date it is unclear how far this practice is followed by child and adolescent psychiatrists across the country.

Most prescribing of atypical antipsychotic medication to children and adolescents will occur in out-patient rather than in-patient settings. We anticipate that the same difficulties described by Tarrant (*Psychiatric Bulletin*, August 2006, **30**, 286–288) in the management of adult out-patients will also apply in child and adolescent psychiatry. In addition, the attitudes of practitioners, parents and children to venepuncture will influence the uptake of these tests. Some children with severe behaviour disorders cannot tolerate venepuncture. In our practice, we believe that recommending blood tests before and during treatment with atypical antipsychotic drugs emphasises the gravity of the decision to use these drugs in children.

With increased concern about the level of obesity and type 2 diabetes in young people in general (Dietz, 2001), psychiatrists and general practitioners need to work closely and cooperatively to decrease the risk of iatrogenic metabolic disease in children and adolescents.

DIETZ, W. H. (2001) The obesity epidemic in young children. *BMJ*, **322**, 313–314.

FINDLING, R. L., McNAMARA, N. K., BRANICKY, I. A. A., *et al* (2000) A double-blind study of risperidone in the treatment of conduct disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, **39**, 504–516.

RUPP AUTISM NETWORK (2002) Risperidone in children with autism and serious behaviour problems. *New England Journal of Medicine*, **347**, 314–321.

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It is well known that psychotropic drugs can have important effects on the cardiovascular system which include changes in blood pressure and effects on the QTc interval (Pacher & Keckskemeti, 2004). The Royal College of Psychiatrists (2006) recommends periodic monitoring by electrocardiography (ECG) during high-dose antipsychotic therapy.

We conducted a postal survey of consultant psychiatrists in the north-west of England to assess the facilities available in the psychiatric clinic for checking blood pressure and the ease of arranging ECG. We also asked whether psychiatrists were confident in interpreting ECG in order to clarify any training requirements. Out of 260 consultants, 132 returned the questionnaire (response rate 50.7%). A majority (59%) felt that it was difficult to arrange ECG in the clinic and worryingly an even higher proportion (61%) lacked facilities to check blood pressure. Only a small minority (13%) felt confident about identifying QT prolongation on ECG. Most

respondents (82%) felt that doctors working in psychiatry should have regular training in interpreting ECG.

These results demonstrate a lack of facilities in mental health clinics for cardiovascular monitoring and the need for regular training of psychiatrists in the care of the physical health of their patients.

PACHER, P. & KECKSKEMETI, V. (2004) Cardiovascular side effects of new antidepressants and antipsychotics: new drugs, old concerns? *Current Pharmaceutical Design*, **10**, 2463–2475.

ROYAL COLLEGE OF PSYCHIATRISTS (2006) *Consensus Statement on High-Dose Antipsychotic Medication* (Council Report CR138). London: Royal College of Psychiatrists.

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Drug-related movement disorders: training needs

We agree that 'psychiatrists need more structured clinical training in assessing and managing [movement] disorders to provide the best clinical care' (Kuruville *et al*, *Psychiatric Bulletin*, August 2006, **30**, 300–303). However, we were surprised that almost all respondents thought that the training should be undertaken in the first year of the MRCPsych course. As senior psychiatric trainees who have recently attended a 'bedside' teaching session on movement disorders, we would argue that there is a need for refresher courses at a later stage of training. Effective continuing professional development should include a regular revision of clinical skills, which cannot be achieved through reading alone. Furthermore, we feel this skill is best learnt in a small group setting with direct patient contact rather than in the more didactic MRCPsych setting. In a small group the learner is able to ask questions more freely.

Kuruville *et al* raise wider issues concerning the competency of psychiatrists in physical examination. Given the increased awareness of biological mechanisms in aetiology, particularly in old age psychiatry and liaison psychiatry, it is becoming increasingly important for psychiatrists to be competent not just in the assessment of movement disorders but all aspects of neurological examination. These are difficult skills to master and should be taught by competent teachers, often working in medical