the columns

correspondence

Difficulties with timely SOADs visits

As we all know, if 3 months have passed from the day on which medication for a detained in-patient was first administered during their current period of detention, incapacitated or refusing patients cannot be given medication to which section 58 applies unless a second opinion approved doctor (SOAD) certifies that the treatment is appropriate. Since the recent amendments to the Mental Health Act came into force,[1] it has been our experience on one occasion that due to the SOAD being unable to visit the patient on time to allow the T3 form (used by a SOAD to certify that medication for mental disorder treatment is appropriate in the case of a detained patient who is either refusing or incapable of giving consent)[2] to be completed, it was necessary to complete section 62. This was to enable treatment of an incapacitated patient who would otherwise have been likely to have deteriorated and to behave aggressively and potentially violently. Two other consultants working in our trust have had to resort to using section 62 in similar circumstances. We can only conclude that the government-led changes in the Mental Health Act, including the introduction of supervised community treatment, have led to these difficulties in obtaining SOADs.

1 Department of Health. *Code of Practice: Mental Health Act 1983*. TSO (The Stationery Office), 2008.

2 Care Quality Commission. *Guidance for SOADs: Consent to Treatment and the SOAD Role under the Revised Mental Health Act*. CQC, 2009.

***E. R. J. Dale** Higher Specialist Trainee in General Adult Psychiatry, The Opal Centre, St Catherine's, Tickhill Road, Doncaster, South Yorkshire DN4 8QN, email Eric.Dale@rdash.nhs.uk, **Chris Kelly** Consultant Psychiatrist, Rotherham, Doncaster and South Humber NHS Foundation Trust

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New Ways not Working and the consultoid

There are many concerns about how psychiatrists' workloads are managed.[1,2] At times, however, the real issues of underfunding and, in old age psychiatry, increasing pathology in an ageing population, are ignored.

I was recently informed that I need to function as a 'consultoid' rather than as a consultant. This sounded rather sci-fi, perhaps like an android or robot, and very surreal. Unfamiliar with the word, I suspected a clever neologism used in a very authoritative way. I checked the online Oxford English Dictionary; it is not there. I thought that perhaps I might try using it when addressing a patient: 'Good morning Mrs X, I'm Dr Hilton, your consultoid'. But it did not sound right. So I searched the internet; consultoid appears to be an imprecise term including people training to be consultants,[3] general practitioners wanting to keep a hand in hospital work[4] and health service developments being made without consultation with clinicians.[5] Indeed, far from sci-fi it is quite an old word, dating at least as far back as 1929.[4]

New Ways of Working with increasing workloads, doctors being removed from the diagnostic, assessment and treatment roles for which they were trained and being 'consultants to the team' is perhaps reconstructing a modern, 'virtual' mental asylum: relatively few medical staff, risk of inadequate diagnoses, almost all work delegated to lower paid staff and where possible offering social care rather than active medical intervention. Perhaps somewhere, sometime, consultoid work will actually be imposed on us from above. But for the moment, just beware if you are asked to be one. It probably implies lower status, less funding, an android-like telepathic sci-fi diagnostic method and mind-reading relationship with the clinical team, plus a superhuman effort to keep up with the workload.

1 Dale J, Milner G. New Ways not working? Psychiatrists' attitudes. *Psychiatr Bull* 2009; **33**: 204–7.

2 St John-Smith P, McQueen D, Michael A, Ikkos G, Denman C, Maier M, et al. The trouble with NHS psychiatry in England. *Psychiatr Bull* 2009; **33**: 219–25.

3 Dunea G. Consultants and consultoids. *BMJ* 1984; **288**: 923–4.

4 Anonymous. The renaissance of general practice (editorial). *Lancet* 1929; **214**: 933.

5 Dr Rant. *Would You Still Trust This Lot?* Dr Rant, 1 May 2007 (http://www.drrant.net/2007/05/would-you-still-trust-this-lot.html).

Claire Hilton Consultant Old Age Psychiatrist, Central and North West London NHS Foundation Trust, Bentley House, 15–21 Headstone Drive, London HA3 5QX, email: claire.hilton@nhs.net

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We need to learn from other doctors

The analysis of current trends in English psychiatric services by St John-Smith *et al*[1] outlines some real problems but does not provide the jobbing clinician (or manager) any practical solutions. I believe other front-line medical services, notably military and primary care, do provide some solutions to help with quality, safety and accessibility in our field.

There needs to be a robust triaging service for urgent referrals, readily accessible to general practitioners (GPs) and other referrers. Consultants should be available on a shift basis to review joint assessments carried out by two (ideally multidisciplinary) staff, also working shifts. This approach has a greater likelihood of avoiding biases in judgements (diagnosis, risks) and decisions (when and where to refer). The UK military field hospitals have much to offer in triaging expertise, as it utilises multidisciplinary assessment and prompt specialist review. The equivalent to field hospitals could be local accident and emergency sites, providing safety and logistic support. Urgent triaging is currently carried out by crisis and home intensive teams, who thereby get put off their main role of avoiding inappropriate psychiatric bed use.

Furthermore, there is an emerging debate whether (or not) a mental health polyclinic staffed by GPs with special interests jointly with non-medical mental health staff would be useful in triaging cold referrals such as anxiety or depression, medically unexplained symptoms and cognitive or memory problems. The relevant experiences stem from musculoskeletal clinics held in primary care or at cottage hospitals around the UK, staffed by GPs with special interests and physiotherapists. A mental health

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