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Increasing the cross-fertilisation of ideas between training schemes

Sir: I have had the opportunity, as the specialist registrar representative on a Child and Adolescent Psychiatric Special Advisory Sub-Committee team, to visit a different child and adolescent training scheme than my own. This was a very interesting experience both with regard to the process of the visit and seeing how another scheme functions. It also exposed me to new ideas about training. I strongly support the view expressed by Laurence Sheldon (1994) that approval visits should be open for any interested specialist registrar and recommend other trainees to consider offering themselves for approval visits.

Further food for thought has come from the biannual joint meetings that the scheme I am on has with a neighbouring scheme. One cannot help but compare one's own scheme and others. Clearly all have strengths and weaknesses and this is discussed among trainees and trainers. Such encounters can be a stimulus for the re-appraisal and development of training schemes.

Schemes will vary according to size, historical context, geography and mix of personalities. Individual training schemes develop particular approaches to problems, using the locally available resources and so will be different. Nevertheless, it is highly likely that some problems will be widespread across many schemes. I would therefore advocate that the cross-fertilisation process between schemes is a significant way of continually improving the training offered.

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Usage of clozapine and new neuroleptics

Sir: Bristow (*Psychiatric Bulletin*, August 1999, **23**, 478–480) found 9.5% of psychiatrists said their trust restricted clozapine funding. By contrast, the Maudsley National Schizophrenia Fellowship (1998) survey of health authority pharmaceutical advisors reported in the *Pharmaceutical Journal* found clozapine funding restricted by 45% of health authorities. We have recently carried out a postal questionnaire of members of the UK Psychiatric Pharmacists Group on the use and evaluation of atypical antipsychotics. We received 82 replies giving a response rate of 45%. Eleven per cent of pharmacists reported their trust capped the number of patients prescribed clozapine. However, there was widespread use of measures by trusts to try and limit expenditure on atypicals, restricting the prescribing of atypicals to consultants only and the use of guidelines in which atypicals are not first line treatment for schizophrenia. Only 12% of trusts, our hospital among them, used no cost-containment measures.

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The law and suicide

Sir: Thompson (*Psychiatric Bulletin*, August 1999, **23**, 449–451), states 'the Suicide Act of 1961 prohibits others from encouraging suicide', and concludes that there may, therefore, exist 'legal grounds' sanctioning suicide Websites. These suggested measures include possibly tracing 'vulnerable individuals' who have disclosed suicidal thoughts, or who have communicated, for example, by way of the site bulletin board, that they have just acted on their suicidal ideation. Yet, it is difficult to see how there could be legal grounds propelling health care professionals (presumably), or any other individual, into such interventions. The Suicide Act 1961, prohibits the 'aiding and abetting' of suicide, but this is not necessarily synonymous with merely 'encouraging' suicide *per se*. Criminal liability arises in circumstances where a person takes active steps in assisting the suicide of another, such as by telling someone the amount of a drug required to secure death and leaving this within their reach. The Suicide Act 1961 does not extend to Scotland, although any individual taking similarly unambiguous steps to assist another in suicide might face 'art and part' liability in the aiding and abetting of a suicide, possibly resulting in a charge of culpable homicide. Neither does it apply to other countries, and it must be borne in mind that assistance in suicide is not a crime everywhere. Therefore, there can exist no competent application of the

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English law or governmental quantitative targets over the conduct of others in a wholly different jurisdiction.

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Is the fictive personality fiction?

Sir: Chaloner (*Psychiatric Bulletin*, September 1999, **23**, 589–66), suggests that being moved by the death of a cultural icon that you have never met, rather than by one's own suffering, may be thought of as a 'fictive personality disturbance'; a pathological process which may be a result of 'ego impoverishment' or a failure of development.

She also concludes that the mass media has encouraged this process which has "become a social norm which goes largely unremarked".

Perhaps this 'fictive personality disturbance' usually goes unremarked because it is unremarkable. A couple of thousand years ago a story went around the Middle East about the tragic death of a local hero. On hearing this tale many people found that identifying with a dead carpenter made their lives meaningful, abandoned their families and even died horrible deaths in his name (Salisbury, 1997).

Prior to the advent of the 'therapeutic state' (Szasz, 1999), Chaloner's patient might have gone to see her priest about her distress. He might have told her that identifying with others, wholly entering into their experience, with a blurring of 'as it' and reality, is part of the great Christian narrative, in which God became man. The priest would, on hearing her confession, offer absolution.

As psychiatrists we give, instead, a diagnosis. We judge her personality and find it undeveloped, 'empty', disturbed or disordered. Rather freeing her from 'sin' we burden her with what Szasz calls a 'discrediting attribute'. We offer her another 'available fiction'; a mental illness, 'an intrinsically stigmatising concept'.

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Mental health legislation

Sir: Szasz's views (*Psychiatric Bulletin*, September 1999, **23**, 517–519) are both illogical and barbaric.

He agrees that our speciality should operate in the same way as other specialities, but denies the existence of mental illness. I can only assume he also denies the existence of illnesses in the medical specialities of "dermatology, gynaecology etc". If this is so, it is had to understand why we need doctors at all. On the other hand, if he accepts that our patients have illnesses, as do other patients, then he must surely accept that at times our patients will be unable to make decisions for themselves, as are other patients. Any other stance is illogical.

To suggest that those with mental illnesses should always be held responsible for all their actions is nonsense. If a person loses consciousness while driving and, as a result, crosses the road into the path of an oncoming car it would seem harsh for that person to be convicted of dangerous driving. There are clearly patients who commit crimes entirely as a result of their mental illness. For such patients to receive punishment rather than treatment would be barbaric.

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Royal College Golf Society

Sir: On the last evening of the Annual General Meeting in Birmingham a small group of intrepid golfers made their way beyond the M40 to the Forest of Arden Golf Course for the inaugural meeting of the Royal College Golf Society. With the addition of a very small number of interloping general practitioners we made up a multidisciplinary band of 24 golfers all intent on a brief period of relaxation after the academic rigours of the meeting. Unfortunately we could not persuade the Continuing Professional Development office to offer us credits for sports psychology, so the altruism of all those who took part is to be applauded.

Although the weather was highly changeable all players managed to get through the round without saturation or other mishaps. The course itself was in excellent condition having been prepared for the club championship, which took place earlier that day.

The overall winner, and therefore current holder of the magnificent silver trophy, is Robert Jackson, who many readers will know as a senior member of the CPD Department in the College. We are all therefore fully anticipating treble CPD points for the next tournament.

This will take place at North Berwick Golf Club on the Friday afternoon at the end of the Annual General Meeting in Edinburgh. So if you are a 'golfer' and do not object to the company of