need for therapists to modify role play techniques accordingly.

GILL SALMON and SHIRLEY ABELL, *Slade House, Oxfordshire Learning Disability Trust, Oxford OX3 7JH*

Audit staff and their role

Sir: I was dismayed that Cook & Langas' review of audit (*Psychiatric Bulletin*, August 1994, **18,** 477) did not mention audit staff at all. I am sorry if the doctors do not have access to an audit department, but if they did many of their concerns would evaporate.

I have been a medical audit officer in general psychiatry for two and a half years. My whole *raison d'etre* is to work on behalf of doctors (not managers, administrators, purchasers) in setting up and carrying out audits. The main duties of audit staff are dataform design, retrieval of notes, data analysis and presentation – in other words, we take care of the administrative parts of an audit that clinicians do not have time to do. In some cases we actually do the audit as well, which educates us but not the trainees.

Audit staff have experience and skills in many different areas. Knowledge of who to see and where to go to find information in such a large organisation as the NHS is invaluable. They should also have access to, and be competent in the use of, a computer, producing good quality forms, reports and presentation materials.

So, we are here, please use us. Let's show that medical audit is effective before clinical audit arrives in earnest and audit manpower and resources are stretched to the limit.

PAUL KIRBY, *Medical Audit Officer, St James's University Hospital, Leeds LS9 7TF*

'Age' should be included in the Trainees' Charter

Sir: I read with interest the contents of the Trainees' Charter (*Psychiatric Bulletin*, July 1994, **18,** 440) in particular, Clause 12, "To be treated with the consideration and respect expected of a professional colleague irrespective of status, sex or race".

Several countries, including the United States and France, provide legal protection against age and discrimination. There is no specific legislative protection against age discrimination in the United Kingdom.

Age as a discriminating factor is now a national issue in the prevailing climate of redundancies and unemployment. Although not a major problem within the medical profession as a whole, age is often perceived as a discriminating factor by a subgroup of overseas qualified doctors settled in the United Kingdom, who tend to be older than the equivalent British qualified doctors. Like myself there are several 'older' trainees of all grades in psychiatry, especially from the ethnic minorities. Being 'older' sometimes hinders the proper consideration of an individual's skills, talents, experience and potential.

The Institute of Personnel Management (IPM) holds the view that "a national campaign is essential to raise public awareness and increase the understanding of employers, employees and their representatives about the harmful business and personal implications of age discrimination in employment". The implications of age discrimination, key facts on the subject and recommendations for reducing age discrimination are clearly laid out in *The IPM Codes of Practice* published in 1993.

The Gwent Community Health NHS Trust, of which I am an employee, has given due recognition to age discrimination by its inclusion in the Equal Opportunities Policy.

I feel strongly that 'age' should also be included among "status, sex and race" in Clause 12 of the Trainees' Charter. It would certainly be a significant step forward and should be considered by the Collegiate Trainees Committee, Dean and Court of Electors.

FATHIMA FAROOK, *Ty Bryn Adolescent Unit, St Cadoc's Hospital, Caerleon, Gwent, South Wales*

Sir: I would like to thank Dr Farook for these comments; we will give them careful consideration when we revise the Trainees' Charter.

STEFFAN DAVIES, *Chairman, Collegiate Trainees Committee*

Need for information about appropriate prescribing

Sir: Mullen *et al*, (*Psychiatric Bulletin*, June 1994, **18,** 335–337) found a wide variation of doses perceived as equivalent among a survey of clinicians. They suggested that this finding was disquieting and that education in this area may be inadequate but the responses of the clinicians may partly reflect the differences that are apparent between various information sources. An important source of drug information is the pharmaceutical companies. Foster (1989) pointed out the recommendations on equivalence provided by these companies differ from each other and from the literature. Schulz *et al* (1989) reported equivalent doses varying by 20–50% depending on which company material was considered. That the BNF offers no guidance on equivalence between oral and depot medication

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and only offers a limited list for oral equivalence adds to the confusion. There is a need for a broader consensus in this area in order that clinicians are better informed as to appropriate prescribing.

FOSTER, P. (1989) Neuroleptic equivalence. *The Pharmaceutical Journal*, September, 431–432.

SCHULZ, P., REY, M., DICK, P. & TISSOT, R. (1989) Guidelines for the dosage of neuroleptics. II: Changing from daily oral to long acting injectable neuroleptics. *International Clinical Psychopharmacology*, **4**, 105–114.

HARRY DOYLE, *Northwick Park Hospital, Harrow HA1 3UJ*

Patient advocacy

Sir: Klijnsma (*Psychiatric Bulletin*, 1993, **17**, 230–231) has described the Dutch model of patient advocacy. We report a case in which potential problems of the advocacy are raised.

N is 55. He has chronic schizophrenia, partially improved by anti-psychotic medication. An attempt to reduce medication in 1993 caused psychotic exacerbation and disturbed, aggressive behaviour. N lacks insight, denying he is ill. He has functional blindness, attributed to the medication which he strongly resists. He is on section 3 of the Mental Health Act and in the past 12 months had this upheld by the hospital managers and a mental health review tribunal. A second opinion doctor supported his current treatment.

When N requested to stop treatment, a nurse arranged for an NSF (National Schizophrenia Fellowship) advocate to meet him. It was suggested that another responsible medical officer (RMO) take over his care, and the advocate helped N to write to hospital management requesting this. It was pointed out by nursing staff (although interestingly never by N or the advocate) that a right to this is contained within the government White Paper *Health of the Nation*. N believed that alternative psychiatrists would take him off his anti-psychotics.

The clinical team had a series of meetings with N, involving the advocate, to try to resolve his agitation and confusion over his current treatment. Consultation confirmed that no other RMO was willing to take over N's care; all those approached supporting a continuation of his depot medication.

During a joint meeting with the advocate, N made allegations that his consultant had murdered patients, and he witnessed horses being killed on the ward. He claimed to have psychiatric training and dismissed his treatment, saying it was an attempt to murder him. The advocate had three meetings with N acknowledged that this was a 'nightmare case', and withdrew.

This advocate was sensitive to the dangers of unrealistic acceptance of N's accusations. The disruption to his care was minimal. The careful long-term relationship built between such a patient and his mental health professionals may be jeopardised in this situation. Had this advocate followed the model of 'true advocacy', in which the patient's right to make his decisions prevails, the advocate would have supported the patient's complaints against his clinical team. However, where (as occurs in schizophrenia) these concerns relate to paranoid delusions involving staff, becoming involved may reinforce their validity for the psychotic patient.

There is no uniform, structured approach to patient advocacy in the UK. The Dutch system appears to have limitations. The authors suggest that mental health professionals need to work with advocates in complex cases, to protect the patient's right to receive proper treatment, and have his/her concerns properly considered.

R. MACPHERSON and B. H. ANSTEE, *Coney Hill Hospital, Coney Hill, Gloucester GL4 7QJ*

The contribution of medical representatives to consultant psychiatrists' understanding and use of psychotropic medication

Sir: I have recently carried out a small study to try to determine whether the work of medical representatives ('drug reps') contributes in a significant way to consultant psychiatrists' understanding and use of psychotropic drugs.

In March and April 1994, I sent out a 15-item questionnaire, to be filled in anonymously, to a total of 60 consultant psychiatrists at hospitals in, and close to, London; 33 consultants (55%) had returned the questionnaires by the end of April. It is self-evident that the sample is unlikely to be representative of the national picture.

The responders segregate into three categories: consultants who agree to see drug reps and who also accept gifts from them (n=16); consultants who agree to see drug reps, but refuse gifts from them (n=6); and consultants who totally refuse to see drug reps (n=11).

As sources of information about psychotropic drugs, drug reps are considered extremely important by none, very important by 9% fairly important by 36%, and not important at all by some 51% of responders.

Sixty-seven per cent of responders do meet reps from time to time, while 33% totally refuse to see them. Of those who do see them, 13% positively encourage their visits and 23% are happy for them to drop in whenever they happen to be around. Seventy-seven per cent of those who see them require them to make specific appointments.

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