columns

impact upon their trust in us? Is our current practice of prescribing this formulation to this population not analogous to offering them a roast beef dinner?

ROBINSON, D., WOERNER, M. G., ALVIR, J. M. *et al* (1999) Predictors of relapse following response from a first episode of schizophrenia or schizoaffective disorder. *Archives of General Psychiatry*, **56**, 241–247.

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Reply

It is correct to state that Zyprexa Velotab (olanzapine orodispersible tablets) contains gelatin as an excipient of the formulation. This information is listed in the Summary of Product characteristics section 6.1. The gelatin is of bovine origin and this information is available from the Lilly Medical Information Department on request. If a patient is prescribed Zyprexa Velotab and is concerned about the bovine gelatin in the preparation because they are vegetarian or for religious reasons, Lilly advise them to discuss their treatment with their doctor who should consider an alternative formulation such as Zyprexa tablets.

If readers are interested in the wider issue of the presence of bovine gelatin in prescription medicines it should be pointed out that the alternative licensed orodispersible atypical antipsychotic Risperdal Quicklet also contains this excipient. Furthermore, bovine gelatin is used as a major structural excipient in the majority of encapsulated medications. This is because it has properties of flexibility combined with rapid solubility, allowing predictable dispersal of the drug. The pharmaceutical industry is investigating alternatives to bovine gelatin, but it should be noted that any change to the formulation of a medicine requires resubmission to the regulatory authorities with the demonstration that the new formulation is bioequivalent to the existing formulation.

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Patient-centred psychiatry

We welcome the article 'Patient-centred psychiatry' (Bhugra & Holsgrove, *Psychiatric Bulletin*, February 2005, **29**, 49–52) providing information and stimulating debate on the likely future of postgraduate psychiatric training.

Currently most trainees spend substantially longer than the proposed 5 years training. It seems that future trainees will have to learn less, learn more intensively or do less service work. The impact on patients and trainers, and resources necessary to implement changes, must be examined in advance. There may be further deterioration in continuity of care, particularly if all posts are for 6 months. Psychotherapy higher specialist training currently takes 5 years; how would this be incorporated into the proposed model? Will sub-specialist ('super-specialist'?) training exist as we know it now? Will special interest and research sessions remain unchanged? Information is also needed on what form assessments might take. It is crucial that factual knowledge remains important within any new competency-based assessment.

What flexibility will exist within the new system; for example: if a trainee wants further experience in a sub-specialty; if a trainee does not achieve necessary competencies within the 5-year period; or achieves them well before this? Consideration should be given to transitional arrangements, for example, for trainees taking time away from psychiatry and returning to a new system.

The College runs training programmes and examinations in jurisdictions not affected by Modernising Medical Careers or the Postgraduate Medical Education and Training Board; trainees in such areas wonder how the proposed new system might affect them.

The authors suggest using the MRCPsych Part I as a 'suitable screen for entry into the specialty'. We would welcome clarification of this. We worry that the College wishes to control entry to training by deeming people suitable or unsuitable for psychiatry. Currently even repeatedly failing the MRCPsych examination does not prevent one from working in psychiatry, but under the new system would this remain the case? Should it?

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False-positive drug tests

A forensic patient tested positive for amphetamine on eight occasions over an 8-week period using a Dade Behring amphetamine/methamphetamine assay. Low concentrations of urinary creatinine in two samples suggested specimen dilution.

Telephone advice from the laboratory emphasised that a positive result from a dilute sample was highly significant. The same advice stated that according to the literature from Dade Behring, chlorpromazine and other medication that the patient was on could not account for the test result. This led us to conclude that amphetamine consumption was recent.

An extensive search for the source of amphetamine proved negative. Subsequent testing of the original samples at an alternative laboratory was negative using both the Cedia kit for an Olympus analyser and the gold standard method of gas chromatography/mass spectrometry (GC/MS).

Closer reading of the literature from Dade Behring revealed a footnote confirming that false-positive results for amphetamine may occur with patients taking chlorpromazine. The advice is that all positive results require confirmation with an alternative method, preferably GC/MS.

The conclusion of Acostsa-Armas (2003) that a positive result on LSD (lysergic acid diethylamide) immunoassay should be confirmed by at least one alternative method can be generalised to amphetamine immunoassays.

National guidelines for testing employees (Steering Group, 2004, section 4.9.3) extend this conclusion to all positive drug tests:

> 'Only drugs which have been confirmed by a recognised confirmation test can be reported as positive.'

The consequences of a positive test for certain patient groups makes following these guidelines of paramount importance.

ACOSTA-ARMAS, A. J. (2003) Problems encountered when testing for LSD in a regional medium secure unit. *Psychiatric Bulletin*, **27**, 17–19.

STEERING GROUP (2004) *United Kingdom Laboratory Guidelines for Legally Defensible Workplace Drug Testing*. http://ramindy.sghms.ac.uk/~ltg/wdtge.pdf

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The new consultant contract in Scotland

In Scotland, in April 2003 the new consultant contract added impetus to job planning. Following some reported problems, the Scottish child and adolescent psychiatry section executive undertook a postal survey of consultants in Scotland in July 2004. Responses were received from 35 (57%).

All respondents had opted to transfer to the new contract, and most had 'definitely' or 'probably' agreed job plans. Six respondents had not – two were in locum posts and for the remaining four there was some dispute. Total sessions ranged from 6 to 12 (36%). Agreed job

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