Correspondence

Couch persons

Sir: Private practice psychiatry is worth scrutinising. Patients slip into a medical office, see the psychiatrist, reappear 50 minutes later and disappear into the crowd. Millions of these contractual relationships are made worldwide each year without any scientific evaluation. Most patients go with depressive illnesses, anxiety states or domestic crises.

Previously we described a venture combining psychotherapy and pharmacology within psychiatry (Eastwood & Shneiderman, 1994). This is a short account of the first year of operations. Sixty patients were referred from psychotherapy for a pharmacology opinion. The patients were middle everything: age, class, income and management. The findings may apply everywhere.

While selected, the population is interesting. The sexes were equally represented, in their mid-40s, and mostly married with children. Women were more likely to be single or divorced. Most men and one-third of women had university education. Most were employed. They had major depression, dysthymia and, then, anxiety states. They were, by nature, frequently fussy, rigid, moody, anxious and shy. Women had worried more than men. Most had friends and interests. They were social drinkers and a few smoked. Most had family histories of depression, alcoholism or suicide. Stressors were marriage, health, work, finances and children. Few needed admittance to hospital. Parasuicide was not an issue. Patients received psychotherapy and SSRI drugs.

Outcome? The antidepressants had proven effectiveness and, assuming good compliance, efficiency. Psychotherapy obviously had not been tested in the same way (WPA Dysthymia Working Group, 1995). Twenty per cent dropped out, 5% needed admittance to hospital, with the remainder a mishmash. The psychotherapist (GS) referred everybody for pharmacology to the doctor at the Clarke Institute (RE). Some found the toing and froing between doctors, understanding protocols and waiting for efficacy, tedious. Nevertheless, 46, or about 75%, continued with the twin treatments: 13 recovered and 33 improved. Outcome, decided between the two doctors, was mostly the opinion of the psychotherapist, since these were his patients.

We combined medication and psychotherapy approaches so that affectively disturbed patients, when calm and cheerful on medication, might deal with life. The patients, busy and functional people, appeared surprisingly well, following treatment. This result, however, will remain unacceptable, to 'evidence based medicine'. Nevertheless, a recent review said, "He (Archie Cochrane) obviously recognized the limited impact of randomized controlled trial (RCT) methodology in psychiatry and one longs to know what adaptations of the method he might have proposed to accommodate these areas such as psychotherapy which do not readily fit the classical design." (Shanks, 1994).

Patients like these are never going to agree to RCTs. Yet depression is so common and so untreated. Which comes first, strategy or incontrovertible scientific proof?

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ROBIN EASTWOOD, *Clarke Institute* and GERALD SCHNEIDERMAN, *Hospital for Sick Children, University of Toronto, Canada M5T 1R8*

Arrangements for MRCPsych examinations

Sir: I was interested to read the letter from Dr P. Sen (*Psychiatric Bulletin*, June 1995, **19**, 380) concerning the way our examinations for the MRCPsych are conducted. There has, of course, been a long tradition in British medicine of the 'sudden death' examination where candidates are given the result shortly after the last viva.

The examinations for MRCPsych involve a large number of candidates, are held in many centres and utilise double marking in all but

the MCQ papers. An examination of this kind does not lend itself to quick decisions. Furthermore, in present conditions 'moderation' of the marks of examinations is seen as desirable to achieve as high a degree of uniformity in the assessment of all candidates as possible. Careful assessment of the marks by a central committee is especially important in our examination where the number of attempts by each candidate is limited.

Some of the difficulties we have in conducting the examinations is illustrated by the example given in Dr Sen's letter, of variations in the approach of different examiners. We hold meetings of new examiners and annual meetings of all examiners partly to assist in providing an assessment of candidates which covers certain key areas of knowledge and practice. However, clinical cases vary widely and we are ultimately dependent upon the judgement of our examiners in assessing a candidate's competence. In the course of the examination the work of candidates is assessed by a series of examiners who each act independently. The Examinations Sub-Committee of the Court of Electors sees all the marks of every candidate anonymously before deciding who shall pass the examination. Only after decisions have been reached on all candidates are the names identifiable by the Sub-Committee.

The examinations for the MRCPsych are bound to remain stressful in some measure; I can only reassure candidates that the College will make the arrangements for the examinations as fair as we possibly can.

R. H. S. MINDHAM, *Chief Examiner, Royal College of Psychiatrists*

How to change prescribing of hypnotics

Sir: Drs Harborne & Tudor's audit study shows how change can come about through the medical audit practice (*Psychiatric Bulletin*, March 1995, **19**, 155–157). We found their paper extremely useful as we have recently tried and failed to recommend a change in prescribing habits of hypnotics.

We initially surveyed a psychiatric in-patient population in May 1994; of the total of 111 in-patients, 36 (33%) were receiving night sedation. The prescribed medications were temazepam for 28 patients (78%) of total prescriptions, chloral hydrate for five (14%) and nitrazepam for three patients (8%). The retrospective examination of psychiatric discharge summaries showed 32% discharged on night sedation (only nine (2.5%) of the 414 summaries had no information of the medication on discharge).

To attempt to change prescribing habits we devised a night sedation policy:

(a) non-drug treatment based on behaviour approach (explanation of insomnia, avoid stimulants, regular eating patterns, exercise, hot milk drink, no daytime naps)
(b) neuroleptic medication, give at night where possible
(c) if prescription is necessary, use p.r.n., after 11 pm, alternate days where possible
(d) drugs of choice: chloral hydrate, temazepam, chlormethiazole and nitrazepam
(e) no hypnotics if the patient is on leave
(f) only one week's supply on discharge.

We met with clinical colleagues and nursing staff, discussed the policy, and presented findings of the initial survey.

At follow-up nine months later, in January 1995, there was no change in night sedation prescriptions, either during in-patient stay or at discharge. In addition to the medical staff failing to follow the recommended guidelines, the night nursing staff also found it difficult to resist some patients requesting the night sedation on a regular basis. We found problems with some patients who did not comply with the recommended behavioural techniques. Finally, we would add that it was relatively easy for us to detect hospital-produced night sedation dependency in contrast to Harborne & Tudor who comment how difficult it was for them to do. We used our comprehensive psychiatric discharge summaries which list medication on admission and discharge.

RAFAEL LOPEZ and JOAN RUTHERFORD
Heathlands Mental Health NHS Trust, Ridgewood Centre, Old Bisley Road, Camberley GU16 5QE

Racism in psychiatric units

Sir: I read with interest 'Sexual harassment of staff by patients in mental health units' by Maria B. Tomé de la Granja (*Psychiatric Bulletin*, March 1995, **19**, 168–169). Not only is sexual harassment a recurring aspect of

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