columns

only two examiners, the candidate is examined over 12 different areas by 12 different examiners. We would have grave difficulty in satisfying examiners as to our competence in this type of exam!

The time available to trainees to perform what we would regard as difficult and complex investigations is not sufficient. It would appear that we should be teaching our trainees that it is right to perform quick, perfunctory, examinations of patients, so that 'snap' diagnoses can be made. Our experience in psychiatry would indicate that this is not a skill that should be seen as beneficial or helpful, either to the psychiatrist or their patient.

It would appear that the OSCE format has been 'borrowed' from the MRCP exam of the Royal College of Physicians. While in general medicine you can make an exam centre around specific clinical tasks, in psychiatry this is much more difficult and can lead to serious problems in understanding. Psychiatry surely is about the whole person; physical, psychological and social. This bio-psycho-social model of psychiatry makes it necessary for assessing psychiatrists to see psychiatric symptoms within their physical, psychological and social context. It is impossible to even attempt such an evaluation within the 6 minutes a candidate has with a patient.

We may live in the age of fast food, fast communications and fast turnover of patients on our wards, but is 'fast psychiatry' something the College should actively promote? We think not. We are still in an age where accurate diagnosis of all aspects of our patients' problems requires careful thought and often time consuming examination. For the College to use this type of format in its professional exam appears to us to be badly thought through, and in urgent need of review.

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Domiciliary phlebotomy

As a practising old age psychiatrist in another part of Mersey Care Trust, I read Darley *et al*'s article on domiciliary phlebotomy for elderly patients (*Psychiatric Bulletin*, April 2004, **28**, 120–122) with interest.

I agree with the authors' conclusion that domiciliary phlebotomy can be a viable method of performing blood investigations in old age psychiatry. However, the financial savings demonstrated in the study might be hard to replicate in other parts of the trust or in other National Health Service trusts.

The main reason for the low cost appears to be minimum distance travelled in each visit (1.4 miles return journey). The average return journey in my patch would be 6 miles. For the 511 visits done in the study, it would mean a total journey of 3066 miles (compared with 730 miles in the study) and it would cost £1165 on travel for the service (compared with £285 in the study).

The financial savings in travel cost would therefore be only £130 (compared with £1010 in the study).

The expenses also do not seem to take into account the cost of employment of the phlebotomist. We have trained one of the support workers in taking blood who provides the domiciliary service for patients unable to attend the community clinic. He also provides the service in the clinic for other patients who attend the clinic for out-patient appointments, thus not necessitating ambulance journeys purely for phlebotomy.

Thus, we have neither needed to separately appoint a community phlebotomist and also have reduced unnecessary ambulance costs by making him available on clinic days.

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the college

Child Abuse and Neglect and Mental Health Services

Council Report CR120
October 2003, Royal College of Psychiatrists, £5.00, 32 pp.

Child abuse and neglect are now recognised as being 'everybody's business'. Aspects of prevention, recognition, assessment and treatment of child maltreatment all fall within the province of the various branches of psychiatry. This document reviews these responsibilities.

Following a definition of child abuse and neglect, the document summarises key documents that have been published recently in England, and their equivalents in Scotland, Wales and Northern Ireland. They include legislation (The Children Act 1989) and government guidance documents accompanying this legislation: *Working Together* (1999), the *Assessment Framework* (2000) and *Safeguarding Children in Whom Illness is Fabricated or Induced*.

Following Lord Laming's enquiry into the death of Victoria Climbie, the government published *What To Do If You're Worried A Child Is Being Abused* (2003). Two documents deal with evidence of children and other vulnerable witnesses in criminal trial and provision of therapy for child witnesses prior to a criminal trial. The Carlile Review, published by the Welsh Assembly in 2002, highlights the vulnerability of children and young people treated and cared for in psychiatric in-patient units. Several documents deal with domestic violence and with patients as parents.

Several issues of practice are addressed. They include multiagency work; culture, ethnicity and gender; confidentiality; the storing of video recordings; and allegations against staff.

A section on selected clinical issues highlights those which were considered to be of particular salience in the field of child protection: vulnerability – including learning and other disabilities and looked after children; transition from victim to abuser; domestic violence; sexual abuse by adolescents; sexual abuse by women; organised abuse; fabricated or induced illness; and the effects on children of adult mental disorder and substance abuse.

The section on research findings includes effects of abuse and breaking the cycle of abuse. These were selected as being of especial relevance to psychiatrists encountering child abuse.

The section on types of professional involvement includes general guidance as well as guidance for specific specialties. The sections discuss the principles of recognition of abuse, investigation and assessment of risk to children, assessment of treatment needs and provision; and medico-legal work.

Lastly, there is a brief mention of training needs.

The report is available for purchase from the College Book Sales Office and can be downloaded from the website: www.rpsych.ac.uk

Proposal for a Special Interest Group in Social Science and Psychiatry

Procedure for establishing a Special Interest Group:

(1) Any member wishing to establish a Special Interest Group shall write to the Registrar with relevant details.
(2) The Registrar shall forward the application to Council.
(3) If Council approves the principle of establishing such a Special Interest Group then it will direct the Registrar to place a notice in the Bulletin, *or its*

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