



the columns

correspondence

Consultant participation in therapeutic management

Sir: The articles by Haigh (*Psychiatric Bulletin*, October 2002, **26**, 380–382), Holmes (*Psychiatric Bulletin*, October 2002, **26**, 383–385) and Davenport (*Psychiatric Bulletin*, October 2002, **26**, 385–388) on the therapeutic management of the acute ward, were timely. It is not easy to manage a busy ward in this fashion but with determination from the consultant and a senior nurse, it is possible and very rewarding.

Contemporary registrar training does not always prepare well for this role. I was lucky to have the benefit of being Douglas Bennett's registrar in the 1960s when I was introduced to this style of management. I then went on to be a co-therapist in an outpatient psychotherapy group with Heinz Wolff. Heinz was a very active therapist and this is more what is needed in a ward group where practically all the patients, if given the option, would rather not be there. In any case, the purposes of the ward group are different from those of outpatient psychotherapy. At their most basic they are a reason for the patient to get out of bed in the morning and an occasion for recognising the existence of each individual. It is important not to exclude a difficult and disruptive patient. Often in the setting of the group, they can respond remarkably well, which makes it a positive experience for all. The group is also a highly efficient way of using staff time, when all the patients attend the group. It is also possible to include patients on special observations, which turns what is usually a tedious task into a therapeutic experience. It is not easy to maintain the group culture against unwilling patients and some unwilling staff and it is much easier if the group is a daily activity, well established and up to the expectations of new staff and patients. The group can also be a great learning experience, and I have never had any problems about including medical students and student nurses. It is vital to have a staff discussion after each group.

The main problem with the system is shortage of staff and staff who are not very experienced or comfortable with the

approach. I had the advantage of having a gifted psychologist, Herbie Pillay, in the team, who offered specific training sessions, which were undermined by the shift system and the shortage of nurses. With the stripping of the inpatient service when priority was given to the community services, I lost psychology, just as I had lost a designated social worker. Because of the need to work as a team, the system works poorly where there are multiple consultants on one ward.

Finally I would like, with the writers, to emphasise the importance of staff groups and the particular importance of the consultant's participation. In his or her absence it is very likely that the group will project their problems on to the absent consultant, who will have his or her paranoid suspicions about what is being said in the group.

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Service provision for gender dysphoria

Sir: I was pleased to read the article by Murjan, Shepherd, and Ferguson (*Psychiatric Bulletin*, June 2002, **26**, 210–212), highlighting the variability of services available for the assessment of individuals with gender dysphoria.

However, I am concerned that their conclusions are not supported by the data provided. They state that "most transsexual people have access to NHS services for the treatment of gender dysphoria". The results presented are that 79/120 (65%) health authorities replied to the survey confirming that they had a commissioning policy, either from local or recognised national centres. It is not stated whether patients were actually referred or seen within a reasonable amount of time. At least one health authority imposes a 5 year "residency criterion" in their area for referral to a specialist service, despite the High Court ruling in *A, D and G*.

The article offers no evidence base for their description of a "full" service, or whether such services as are provided are effective. Worryingly, the authors refer to the 5th edition of the Harry Benjamin International Gender Dysphoria Associa-

tion (HBIGDA) *Standards of Care for Gender Identity Disorders* (1998), which differs significantly from the current 6th edition (2001).

The authors infer that there is a need for a standardised treatment approach across Great Britain, and attribute the negative experiences of patients using specialist gender identity services to inadequate commissioning of local services. Neither inference is justified by the data presented. The implicit call for uniformity is at odds with the HBIGDA standards of care, and potentially wasteful of resources.

HARRY BENJAMIN INTERNATIONAL GENDER DYSPHORIA ASSOCIATION (1998) *The Standards of Care for Gender Identity Disorders*, 5th Edition. Dusseldorf: Symposion Press.

— (2001) *The Standards of Care for Gender Identity Disorders*, 6th Edition. Dusseldorf: Symposion Press.

MURJAN, S., SHEPARD, M., FERGUSON, B. G. (2002) What services are available for the treatment of transsexuals in Great Britain? *Psychiatric Bulletin*, **26**, 210–212.

A, D and G v NW Lancashire Health Authority, Court of Appeal 29 July 1999, Case Nos. QBC 1999/0226/4, 0228/4, 0230/4.

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Sir: I read with interest the paper by Murjan, Shepherd and Ferguson (*Psychiatric Bulletin* June 2002, **26**, 210–212).

In their assessment of services provided to transsexual patients, the authors relied on the 5th edition of the Harry Benjamin International Gender Dysphoria Association *Standards of Care for Gender Identity Disorders* (1998). In doing so they omitted to refer to the current edition which is the 6th edition, (2001), with revised standards and a modern approach favouring flexibility, rather than uniformity of provision. The current edition concludes that "in some patients, hormone therapy alone may provide sufficient symptomatic relief to obviate the need for cross-living or surgery".

The unfortunate consequences of the authors' use of the old edition are manifest in two ways. First, their implicit criticism of a Health Authority for commissioning hormonal therapy without surgery for transsexual people; and