the columns

correspondence

Improving working lives

I have read with interest Peter Kennedy's editorial on the issue of locum consultant psychiatrists (*Psychiatric Bulletin*, August 2003, **27**, 281–282).

A healthy work environment, adequate support facilities, decent working conditions, appropriate workload, supportive colleague group and a receptive management are essential ingredients for maintaining good recruitment and retention of a highly-skilled workforce.

A pathological reliance on a locum consultant workforce on part of a NHS trust may be viewed as an indicator of deep-rooted problems, rather than the single most important issue in itself.

NHS trusts rely heavily on local and regional specialist registrar training schemes to attract new consultants. By the time trainees are near their completion date for award of the Certificate of Completion of Specialist Training, they usually have a good idea about strengths and weaknesses of potential prospective employers in the region. It does not come as a surprise when some trusts fail to attract and appoint new substantive consultants. Even popular employers often fail to attract a substantive workforce for their known 'problematic' posts. This is the work-culture where a market for locums thrives.

It would be unethical to call locum colleagues 'mercanaries' after contracting their services, whatever the agreed rate of pay may be. Senior managers should rather concentrate on better service and workforce planning to improve the working lives of their staff. This is the only light at the end of the tunnel, if the situation is to improve in the future. Any proposals to force the existing workforce to cover the workload of unfilled vacancies may cause more damage.

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Advance directives in mental health

In discussions about our recent research in advance directives in mental health a number of people indicated that they would put in an advance directive refusal of certain medication because they were 'allergic' to it. Any patient who tells a treating doctor they are allergic to, say, penicillin should be confident that they would not receive this drug. Some psychiatric patients, however, believed that telling a doctor they were 'allergic' to a particular drug would not prevent them being given it. This raises the question of what they mean by 'allergic'. If patients mean that it causes, to them, unacceptable side-effects but have learnt that this is not an acceptable reason to psychiatrists for not prescribing it, they may be seeking what they believe to be a more acceptable 'medical' reason.

Advance statements are included in the new Mental Health (Care and Treatment) (Scotland) Act 2003 and may appear in new legislation in England and Wales. To serve their purpose, they need to be written clearly and unambiguously. If patients cite allergy as a reason for not receiving a drug and this can be overturned by a doctor who has a different understanding of what allergy means, the advance directive will not serve its purpose. It is more appropriate that psychiatrists work with patients to encourage them to express their concerns, accept them as legitimate and seek to overcome them, as many undoubtedly do, rather than patients adopt a possibly inappropriate term in an attempt to make their views heard.

Declaration of interest

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The utility of EEG in psychiatry and aggression

The apparently dismal performance of routine electroencephalogram (EEG) in psychiatry reported by Stone & Moran (*Psychiatric Bulletin*, May 2003, **27**, 171–172) needs further qualifying.

First, how many of the requests were made by trainees without consultant or responsible medical officer approval?

Second, the 'catch rate' for other physical investigations in psychiatry is not high but obviously vital for the individual patient.

Third, how many of the 68 'non-diagnostic EEGs' found temporal lobe dysfunction and were the patients further evaluated to exclude temporal lobe epilepsy?

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Author's reply

We agree with Dr Hambridge that trainees can have of a tendency to order more unnecessary investigations than consultants, although for an expensive investigation such as an EEG, one would hope that the consultant in charge would approve the request. Unfortunately, we did not collect data on this. We also agree that sometimes investigations must be carried out even if the expected yield is low. An EEG looking for evidence of diffuse slowing that might indicate an organic brain disorder is a particularly useful indication.

We were not advocating that psychiatrists must never request an EEG, but that they should be aware of its considerable limitations, particularly in the diagnosis of epilepsy. The fact that 29 of the 187 EEGs demonstrated temporal lobe dysfunction is of little help in the diagnosis of temporal lobe epilepsy, first, because the diagnosis of temporal lobe epilepsy depends primarily on a good history and witness account and second, because of the frequency of temporal lobe dysfunction, both in the population and in a number of psychiatric disorders.

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