



guidance in the Code reflects the qualification of autonomy for detained patients. It can also be applied to the additional reduction of autonomy, which may be experienced by the child patient, even if the child's legal status is informal. The Code reflects reality, tacitly acknowledging an abridgement of autonomy, which in certain circumstances will result in detention.

As the Code correctly summarises the law it is incorrect to state that it 'creates' inconsistencies (Parkin, *Psychiatric Bulletin*, October 1999, **23**, 887–889) or undermines the child's rights. All the Code does is highlight what may be regarded as the conflicts between the current law, current clinical practice and the child's human rights. This is the area where the debate needs to be focused. In particular whether the competent child's human rights have been infringed where a decision to override their treatment decisions has been made.

References

RE: F (1990) 2 AC, 1.

RE: M (MEDICAL TREATMENT CONSENT) (1999) 2 FLR, 1097.

RE: W (1992) All ER, 627.

Anthony Harbour, Solicitor, ***Sue Bailey**, Consultant Adolescent Forensic Psychiatrist, Adult Forensic Service, Mental Health Services of Salford, Bury New Road, Prestwich, Manchester M25 3BL, **William Bingley**, Chief Executive, Mental Health Act Commission

Serotonin syndrome

Sir: Mir & Taylor (*Psychiatric Bulletin*, December 1999, **23**, 742–747) in their review of serotonin syndrome reminded us of the diagnostic criteria (Sternbach's criteria) for the diagnosis of this syndrome at a time when we had recently changed the drug therapy of a patient from trazodone to paroxetine. In this patient we saw the emergence of five symptoms listed in Sternbach's criteria (agitation, myoclonus, shivering, tremor and incoordination). We have two points to make: we noted that the most severe symptoms in this patient were nausea and vomiting. Although, it is accepted that nausea and vomiting may occur as part of the serotonin syndrome (Lane & Baldwin, 1997) they are not diagnostic criteria. Gastrointestinal symptoms are well-recognised effects of increased serotonergic activity and it is surprising that there is little emphasis on them in the literature relating to this subject. Where serotonin syndrome is a result of changing drug therapy the possibility of a discontinuation syndrome should be considered as an alternative diagnosis because of the

overlap in symptomatology between the two syndromes.

References

LANE, R. & BALDWIN, D. (1997) Selective serotonin reuptake inhibitor-induced serotonin syndrome: Review. *Journal of Clinical Psychopharmacology*, **17**, 208–221.

ROSENBAUM, J. F. & ZAJECKA, J. (1997) Clinical management of antidepressant discontinuation: Review. *Journal of Clinical Psychiatry*, **58** (suppl. 7), 37–40.

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Sir: It may be helpful for clinicians to appreciate that the great weight of recent evidence indicates that a spectrum model best explains serotonin syndrome phenomena. Serotonergic side-effects merge imperceptibly into 'toxic' effects or serotonin syndrome. Much confusion exists in the literature because in many reports an insufficiently precise distinction is being made between side-effects and toxicity.

At present the evidence is that life-threatening morbidity or mortality, only arises from combinations of monoamine oxidase inhibitors (this definitely does include so-called 'RIMAs' (reversible inhibitors of monoamine oxidase A) such as moclobemide) and drugs able to act as serotonin reuptake inhibitors (which includes some narcotic analgesics). The risk remains unclear for catechol-O-methyltransferase inhibitors.

I also wish to draw attention to some valuable prospectively gathered and systematically documented data specifically addressing the issues of what symptoms and signs characterise toxicity from various drugs when taken in overdose. These data come from Ian Whyte's group. In a series of over 5000 cases of self-poisoning 10% were with a single, primarily serotonergic, drug. Of these, 16% met the Sternbach criteria for serotonin syndrome.

The only serotonin reuptake inhibitor that was significantly different from the reference drug (sertraline) in its frequency of association with the serotonin syndrome was clomipramine, with which serotonin syndrome was only one-tenth as frequent (odds ratio 0.1 and 95% CI was 0.0–0.9). This may be because clomipramine is a potent 5-HT_{2A} antagonist.

Our extensive database of references about serotonin syndrome is available to researchers at www.psychotropic.com.

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Sir: Mir & Taylor (*Psychiatric Bulletin*, **23**, 742–747) make an error in their article on serotonin syndrome. They start their article by stating that serotonin syndrome appears to be a new phenomenon; this is untrue. Serotonin syndrome is well-known to be an element of the carcinoid syndrome, a medical disorder characterised by high levels of circulating catecholamines due to inappropriate secretion by a tumour, for example, of the gut or adrenal medulla. This is not a drug side-effect.

The implications of this are potentially serious; a patient could present with the symptoms described without having a drug-induced serotonin syndrome, and the differential diagnosis is not discussed in this paper. The sections on 'Causes of serotonin syndrome' and 'Biochemical mechanism of serotonin syndrome' are, therefore, dangerously misleading. This could result in missed diagnoses of carcinoid syndrome, or misattribution of systemic serotonergic effects because other causes have not been considered.

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College comments on the Fallon Inquiry

Sir: I refer to Dr Veasey's letter (*Psychiatric Bulletin*, November 1999, **13**, 690) asking who at the College was responsible for the College's comments on the Fallon Inquiry Report on Ashworth Hospital. I thought it appropriate to reply to Dr Veasey. I am now well briefed and informed about the controversy which gave him particular concern.

In this regard my information is that the College's response to the report on the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital (chaired by Judge Fallon) was first drafted by my predecessor Dr Robert Kendell and then finalised, following extensive discussion at the Executive and Finance Committee and then subsequently at Council on the 3 February 1999. I am sure that the intent was not to act in an unjust and unfair way against any individual psychiatrist. Let us hope, however, that structures are now in place which will make this fraught situation less likely to occur in the future.

John L. Cox, President, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG

Martial arts for psychiatrists

Sir: Once a peer-reviewed article appears in a reputable journal it carries a certain cachet of validity, any editorial disclaimers



to the contrary notwithstanding. The November 1999 issue of the *Psychiatric Bulletin* (23, 641–701) is a good example of this. The first three or four articles include stimulating discussions on evidence-based medicine in psychiatry (Laugharne) and a balanced and critical article on community treatment orders (Moncrieff & Smyth) with an equally penetrating commentary (Burns). Articles by Davies & Oyeboode analyse the application of modern methods of risk management to psychiatric care. Then, quite suddenly, an extraordinary paper appears from Pereira *et al* giving (literally) blow-by-blow instructions on how to restrain and overcome protesting patients and force them to take clozapine therapy. Ethical considerations are dismissed in one sentence at the end. The commentary paper by Barnes also deliberately excludes any discussion of ethical aspects, but briefly sets out some practical reasons why it would not, in any case, work. Ironically, other papers in the same issue express concern at excessive dosages of antipsychotic medication being given to patients by some psychiatrists (Tyson *et al*) and another by Lawrie bemoans the stigmatising attitudes of the general public to psychiatric patients.

The martial arts manual by Pereira *et al* is provocatively entitled 'When all else fails'. This letter is written in the same spirit. I am concerned that this article was published at all, since it could be interpreted as incitement to violence – by psychiatrists – and be endorsed as such. Any such endorsement, however

inaccurate and misleading it might be, could conceivably bring psychiatry into disrepute. I sincerely hope my fears in this respect are unnecessary and in any case I cannot think what can now be done to remedy the situation. I shall have to content myself with writing to doctors Moncrieff & Smyth to ask for further details of the campaign mentioned by them to oppose the introduction of community treatment orders which, thankfully, are not included in new mental health legislation now being introduced in Ireland.

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Estimating bed occupancy

Sir: Peter Greengross' recent article on the pressure on acute adult psychiatric beds was a useful attempt to quantify an important problem (*Psychiatric Bulletin*, February 2000, 24, 54–56). There has been little published about the experience of clinicians outside of London and this paper would appear to confirm that similar problems occur, particularly in southern regions. Such findings have implications for future resource allocation and should inform local strategic planning.

Unfortunately, the approach used, although producing a rapid overview, has disadvantages. Any survey that is reliant on postal response to questionnaires is open to response bias. The chief executive

of an NHS trust when invited to comment whether beds are, 'over-occupied', 'rarely, sometimes, or frequently', is being asked to define what he or she considers is the ideal rate of bed occupancy and then give an estimate of what is occurring locally. This arbitrary estimate will, at best, follow consultation with medical records and clinicians. It may simply be a subjective estimate based on anecdote.

At a time of change in emphasis towards community-based resources, planning can only be based on reliable information. Quantification of a perceived problem can only occur with, 'real', data and this is best produced by a census approach as suggested by the authors. Kennedy (2000) has recommended a systemic approach to the needs assessment, involving an initial mapping of the services available to psychiatric patients, including specialist services. This would be more informative, as the pressure on acute adult psychiatric beds is likely to be related to the availability of longer stay beds, thus better informing strategic planning.

Reference

KENNEDY, H. (2000) *Needs Assessment: Recent Advances and Toolkit*. Presentation at the Residential Conference of the Royal College of Psychiatrists. Cardiff.

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the college

Nominees elected to the Fellowship and Membership under Bye-Law III 2(ii)

At the meeting of the Court of Electors held on 15 February 1999, the following nominations were approved.

Fellows – UK

Dr Patricia Mary Abbott, Dr Helen M. Anderson, Dr Gary Bell, Dr Anthony P. Boardman, Dr Sikander Abbas Bokhari, Dr Michael P. Bourke, Dr Daniel M. Brennan, Dr Martin H. Briscoe, Dr David P. K. Brown, Dr Aggrey Burke, Dr Sheila A. Calder, Dr Lachlan B. Campbell, Dr Maria T. G. T. Campbell, Dr Peter K. Carpenter, Dr John F. Connolly, Dr Sarah Anne Davenport, Dr Shamim Dinani, Dr Stephen Edwards, Dr Morad El-Shazly, Dr Kim Fraser, Dr Nilani P. Gajawira, Dr Richard A. Gater, Dr John R. Geddes, Dr Raymond Goddard, Dr Stephen Hunter, Dr Chuda Karki, Professor Michael B. King, Professor James Lindesay, Dr Hilary Lloyd, Dr Hameen R. Markar, Dr Caroline

Marriott, Dr Brian V. Martindale, Dr Maria G. A. McGinnity, Dr Kenneth Merrill, Dr Niall Moore, Dr John R. Morgan, Dr Andrew W. Procter, Dr Mohammed Abdur Razzaque, Dr Stephen P. Reilly, Dr Drew Ridley-Siegert, Dr Philip J. Robson, Dr Mangaytkarasy Sabaratnam, Dr Kamran Saedi, Dr Lester Sireling, Professor Graham J. Thornicroft, Dr Ariyadasa Ubeysekara, Dr Nicholas Wagner, Professor Simon Wessely, Dr Peter Wood.

Fellows – overseas

Professor Cliff Allwood, Dr Zeinab Bishry, Dr David R. Dossetor, Dr Kandath V. Girijashanker, Dr Yan Ming Ip, Dr Jacob K. John, Dr Siu Wah Li, Dr Norman Moore, Dr Kenneth Nunn, Professor Helmut Remschmidt, Dr James Rodney.

Membership under Bye-Law III 2(ii) – UK

Professor Anthony R. Kendrick, Dr Gabriel Kirtchuk, Dr Kolappa Sundarajan.

Membership under Bye-Law III 2(ii) – Overseas

Dr Chwen C. Chen, Professor Afaf H. Khalil, Dr Nicolino Paoletti

Election of President

Notice to Fellows and Members

Fellows and Members are reminded of their rights under the Bye-Laws and Regulations, as follows:

Bye-Law XI

The President shall be elected annually from among the Fellows.

Regulation XI

(1) As soon as may be practicable after the first day of June in any year the Council shall hold a nomination meeting and shall . . . nominate not less than one candidate and not more than three candidates . . .