



columns

further improvements among more severely ill or difficult to treat patients, complementing the 'average' patients studied by Fleischhacker *et al*. Hopefully, readers will consider the full report before reaching conclusions about the potential impact of long-acting risperidone for their particular patients.

FLEISCHHACKER, W. W., EERDEKENS, M., KARCHER, K., *et al* (2003) Treatment of schizophrenia with long-acting injectable risperidone: a 12-month open-label trial of the first long-acting second-generation antipsychotic. *Journal of Clinical Psychiatry*, **64**, 10, 1250–1257.

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Perverse incentives

Whether or not the incentive to be able to retire early from what your survey confirms to be an overworked and undervalued profession is 'perverse' (*Psychiatric Bulletin*, April 2004, **28**, 130–132) is a matter for debate. Nevertheless, many psychiatrists will undoubtedly have taken it into account when choosing their career. More to the point, many mental health officers (MHOs) will have made important financial planning decisions based upon a 'guarantee by law' (A guide to the National Health Service (NHS) pensions scheme, National Health Service Pensions Agency, 2001) that such an entitlement will remain in place. Given that there may be moves by the government to change the law and hence remove such a guarantee, do the authors not consider it unwise to describe what many consider to be one of the few 'perks' of psychiatry in such a way?

Given the substantial financial incentives of non-NHS work, have the authors not considered the potentially disastrous consequences for an already strained profession that the removal of MHO status might lead to?

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Retirement

Pleased initially simply to have avoided the cut on being an 'older' psychiatrist (Mears *et al*, *Psychiatric Bulletin*, 2004, **28**, 130–132), I reflect that past 45, I enjoy my job, have a great team of colleagues and rarely complain about my income – only my outgoings. Having left two consultant posts behind me (happily filled), I hope to train somebody to jump aboard when I shuffle off at 55 or 56. This may be too early to retire from life, but as the old joke observes, nobody lies on his deathbed

mourning that they hadn't spent more time in the office. Unless the world is turned upside down, there will be no shortage of part-time, locum, medico-legal and private work to do should I wish to continue as a psychiatrist. If I'm spared, I might prefer a life change.

The average age of the sample was 56, so it is unsurprising that those still registered and compos mentis were still working. I wonder how many of the sample with mental health officer status planned to work beyond the point at which they achieve maximum pension? Nobody I know has stayed more than a year or two. If appearances are anything to go by, most of them look 10 years younger within months of retirement. I will be surprised if your columns are full of post-retirement psychiatrists bemoaning their premature trips to the sun: they'll all be too busy to write.

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Sociological support for importance of complementary and alternative medicine (CAM)

The timely article by Bhugra *et al* (*Psychiatric Bulletin*, February 2004, **28**, 36–39) may not be welcomed by all readers. Therefore, I would like to support their view that psychiatrists – and indeed other physicians – should take an interest in whatever their patients resort to for relief of symptoms. For additional reading, I recommend a chapter by Goldstein (1999). Already more than 10 years ago, it was estimated that Americans made considerably more visits to unconventional providers than to all primary care physicians. By so doing, they spent \$13.7 billion more than they spent out of pocket on conventional care that same year. Some insurance companies and health maintenance organisations offer coverage for some forms of alternative care. Listings in the *Healthy Yellow Pages* for Los Angeles are hilarious and informative alike.

In the 16th century, few liked to believe that the earth is not the centre of the universe. Now, most medically trained people prefer to perceive themselves as central to providing health care. The perspective seems to be different for many on the receiving end.

GOLDSTEIN, M. S. (1999) The growing acceptance of complementary and alternative medicine. In *Handbook of Medical Sociology* (ed C. E. Bird, P. Conrad & A. M. Fremont), pp. 284–297. Harlow: Pearson Education Limited.

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Liaison psychiatry

I would like to echo the view of liaison psychiatry expressed by Dr Bolton (*Psychiatric Bulletin*, April 2004, **28**, 149). When I moved to Wolverhampton nearly 6 years ago, there was a very well thought of nurse-led liaison psychiatry service which as well as providing an excellent response to the local accident and emergency department also was developing links with particular specialties. The service had been based at the general hospital along with the psychiatric beds, but when the latter were relocated to a purpose-built facility on a different site in December 2002, the liaison service lost its accommodation on site. Foreseeing this, we had provided a detailed service specification well in advance of the move; we were later told this had been 'lost', so resupplied it. At around the same time, there was a change in management as we were absorbed into the primary care trust and senior management became very interested at the point where it became clear that there had never been a service level agreement with the acute trust. The service was entirely funded from mental health, apart from one seven session psychology post that continues to be funded by the acute trust.

A number of meetings have taken place between senior management and clinicians between the primary care trust and the acute trust but these have proved frustratingly inconclusive. Despite the fact that my one or two sessions of input to the service remain significantly below the recommended norm of about two full-time equivalents for the size of the hospital, the team has continued to provide a well-thought of service which is valued by clinicians in the acute trust. Goodwill has not translated into funding however, and because the primary care trust has entered the new financial year short of cash, it is proposing to cut two nursing posts and redeploy the third into another needy area of mental health. The thinking behind this is presumably along the lines; 'If it ain't broke . . . let's tinker with it until it is, and then we can abolish it . . .'

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The objective structured clinical examination (OSCE)

The objective structured clinical examination was introduced in spring 2003 as a more comprehensive and a fairer method of assessment of the clinical abilities of the candidates for the Part I MRCPsych. It was thought that this method would examine candidates' clinical abilities over more clinical subjects than the traditional long case could achieve. Instead of having