that those who participate in CPD are less likely to be disciplined than those who do not and that those who are in mature professional years fare better if they keep up to date with modern practice.[5] There is scope within the three domains (clinical, professional and academic) of the new CPD policy to cover all specialty developmental issues while retaining generic medical and psychiatric skills. These might be further reinforced through peer groups. Each of the College faculties has had the opportunity to influence the policy, but I am in agreement with O'Leary *et al* that further refinement could take place to reflect the growing need to provide specialist care. It would be my aspiration that the CPD policy be more electronically based rather than being set in a publication which sits on the shelf for the next 5 years or more without being updated. I would welcome members' input into how this might be achieved annually, with revision of policy that is in line with their practice.

Declaration of interest
J.S.B. chairs the Royal College of Psychiatrists' CPD Committee.

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doi: 10.1192/pb.34.11.497c

Routine outcome measures in liaison psychiatry

Jacobs & Moran,[1] in their article enthusiastically supportive of the use of Health of the Nation Outcome Scales (HoNOS) as a routine outcome measure, recommend 'mild coercion' by trust managers to improve completion rates. They acknowledge the bluntness of the instrument and its inappropriateness in some specialist services but fail to consider that it may be totally inapplicable in some psychiatric specialties, one of which is liaison psychiatry.

The authors state the truism that for HoNOS to be considered an outcome measure, there need to be paired ratings. Liaison psychiatry services see patients mainly in emergency departments (A&E) and in-patient medical units. The A&E assessments are mainly one-off assessments where paired assessments are inapplicable. The average stay for acute care in the UK is about 6 days;[2] thus there are few patients on medical wards where paired ratings with a space of at least 2 weeks between them are possible.

Another problem in using HoNOS as an outcome measure, even in the few cases where it may be possible, is the nature of consultation–liaison work. The consultations are often directed at the referring medical team, examples including clarifying a complex capacity situation or advising on change in psychopharmacology in patients with organ impairment. Even when the consultation is patient-focused the interventions are not necessarily aimed at bringing about symptomatic change in a short period of time. Thus, HoNOS would at best fail to capture relevant outcomes and at worst seriously misrepresent the effectiveness of liaison psychiatry teams.

This is not to say that outcome measures are not important in liaison psychiatry but they need to be smarter. Operational definitions for consultation outcomes that focus on the effectiveness of individual consultations should be agreed – such an approach has been recently studied by a Brazilian group.[3] Quality of liaison psychiatry services should be judged by looking at consultation outcomes and performance standards such as those recently published by the Psychiatric Liaison Accreditation Network.[4]

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doi: 10.1192/pb.34.11.498

Women in academic psychiatry: view from India

Dutta *et al*[1] discuss various reasons for underrepresentation of women psychiatrists in senior positions across academic medicine from high-income countries. We would like to share our experience from India as a representative of low-income countries.

Over the past few decades, the number of women psychiatrists in India has been on the rise and they constitute about 15% of the total number of psychiatrists. However, most of them work in junior positions, with only about 10% in senior positions.[2] The women psychiatrists in India are represented in different health sectors such as general hospital psychiatric units, psychiatric hospitals and the office-based practice. The majority of the premier medical schools of the country have women faculty but mostly in junior positions. Some also head academic departments in different parts of the country, and a few have headed a medical school in the past. Some of the women psychiatrists in the country have also taken leadership roles in areas of child psychiatry, suicide prevention, community psychiatry, rehabilitation of patients with schizophrenia and issues related to women's mental health. A few have held the position of the President of the Indian Psychiatric Society, the national body of psychiatrists. Although the *Indian Journal of Psychiatry*, the official journal of the Society, has never had a woman editor, some of the journals published by the constituent zones of the national Society did have women editors. One of them, the *Journal of Mental Health and Human Behaviour*, is edited by a woman psychiatrist. Critically seen as a whole, the original articles and some case reports make the