First, regarding the methodology of the study, the choices for the clinicians were unnecessarily polarised where only one option out of four (A–D) could be chosen. It is thus not surprising that the views somewhat reflected this false polarisation. This may be an indicator of the limitations of a questionnaire-type study, so it would be fascinating to conduct a more qualitative type study in which some of the issues could be explored and examined in depth.

Our personal view is that the joint approach which incorporates both options A and B (that is, psychiatry referring to primary care, as well as providing simple management around nutrition and exercise) could have been another option. This echoes the values behind the National Institute for Health and Clinical Excellence (NICE) guidelines for schizophrenia,[2] where joint monitoring (and, by extension, management) of physical health is emphasised in their recovery promoting statements.

Second, it is worthwhile to look at current guidance on prescribing – the *British National Formulary* (BNF) clearly states that any prescribing of medication should be discussed – including the risks and benefits – with the patient.[3] NICE also highlights this in a patient-centred approach to care.[2]

With these points in mind it is important to assume that whatever option is taken, there has been a discussion with the patient about the possible adverse effects of medication[4] and it would be interesting to explore what is said about who is responsible when such side-effects occur. Ideally, the patient ought to seek advice from the prescriber in the first instance. However, if the prescriber is the GP, some patients may find it easier to access their psychiatric team first, who would subsequently contact the GP on their behalf.

The backdrop to these comments is that we are a psychiatrist and GP who have, through our own efforts, come to the conclusion that real, effective collaborative working means face-to-face meetings. We look after a small 24-hour-supported placement in London, which houses 13 residents (mean age 49 years) whose disease is at the severe end of the mental health spectrum.[5] Usually, most residents will attend the surgery with the key-worker, although this is never guaranteed and sometimes there is the call for a home visit.

The level of morbidity is high. Currently, 54% of the residents have non-insulin-dependent diabetes and 70% have hypertension, with one resident having dialysis three times per week. Additionally, most smoke heavily and the mean body mass index of all residents is >30. The psychiatric team continue to reiterate advice on healthy eating, exercise and smoking cessation, whereas the GP practice initiates any necessary medication for metabolic dysregulation.

Since working together on the project we have increased flu vaccination rates every autumn (from 20 to 90%) and developed some innovative ideas regarding positive health promotion. For example, residents are invited to attend a walking group and we are currently attempting to engage a dietician specifically to give advice to both residents and staff.

We agree with Bainbridge *et al*'s conclusion that 'clearly defined roles for mental health services and primary care in the management of metabolic complications are of paramount importance'. However, we are of the firm belief that to delineate such roles there is no substitute for face-to-face meetings where patients are jointly discussed, monitored and managed.

1 Bainbridge E, Gallagher A, McDonald G, McDonald C, Ahmed M. General practitioners' attitudes on who should manage metabolic dysregulations associated with antipsychotics. *Psychiatrist* 2011; **35**: 213–5.

2 National Institute for Health and Clinical Excellence. *Core Interventions in the Treatment and Management of Schizophrenia in Adults in Primary and Secondary Care (Clinical Guideline CG82)*. NICE, 2009.

3 British Medical Association, Royal Pharmaceutical Society of Great Britain. *British National Formulary* (issue 61). BMJ Group and Pharm Press, 2011.

4 Mackin P, Thomas SHL. Therapeutics: atypical antipsychotic drugs. *BMJ* 2011; **342**: d1126.

5 NHS Lewisham. Health, Well-Being and Care: Lewisham Joint Strategic Health Needs Assessment. NHS Lewisham, 2010 (http://www.lewishampct.nhs.uk/documents/2331.doc).

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Correction

Obituary for Professor John Anthony (Sean) Spence. *Psychiatrist* 2011; **35**: 319. Professor Sean Spence was formerly Professor of General Adult Psychiatry, Sheffield University. The publishers apologise to Professor Peter W. R. Woodruff for this error.

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