



columns

secondary handicap and promote social and cultural reintegration (Royal College of Psychiatrists, 2004).

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doi: 10.1192/pb.31.8.315b

Simulated patients

As a former professor of psychiatry and a current simulated patient I was interested in the paper of Eagles *et al* (*Psychiatric Bulletin*, May 2007, **31**, 187–190). I have been doing such (voluntary) work for about 5 years, simulating psychiatric and general medical/surgical patients both for teaching sessions and in objective structured clinical examinations (OSCEs). I have also participated in OSCEs for higher exams for occupational health medicine but not yet for psychiatry. I find it a very interesting experience, and so far have not succumbed to the stress mentioned by Eagles *et al*. There is a bank of some 400 of us in Sheffield, a mixture of volunteers, actors, 'real ex-patients' and former clinicians of various specialities.

The usual practice is to be given a script about a week before, and once learnt one can usually trot it out realistically about 10–15 times in a day, spread over 4 or 5 sessions. I have been prepared to take on more or less any condition – the only one I drew the line at was that of a 27-year-old with schizophrenia; it wasn't the schizophrenia which troubled me, but I just could not satisfy myself I could act the 27 years convincingly. It was taken on by a younger actor.

We also lend ourselves for standard physical examination – blood pressure, temperature, chest examination, etc. In these days of MRSA, I was undergoing a chest examination in a rather draughty room; the young lad came in his white coat, duly washed his hands with alcohol rub, said 'Oh my hands are cold' and proceeded to rub them on his white coat to warm them before he put them on my chest. Does he get failed for poor hygiene, or a distinction for concern for the patient's comfort?

Another heart-warming incident occurred at the end of a lecture in which I was demonstrated as a widowed hypertensive patient living alone who was worried in case he collapsed and fell down

the stairs. A young student came up to me and said, 'I hope you don't mind me telling you, but my granny is like you, but she has an alarm round her neck and she can call for help if she needs to.' Another distinction.

On one occasion I was there for an abdominal examination when one of the demonstrators was called away for an emergency. I found myself taken out of bed and reverted to being a doctor, teaching for the rest of the morning.

You can appreciate I find it a rewarding, entertaining and amusing experience, perhaps repaying some of the satisfaction I achieved during my teaching and clinical career. I think it is true to say that the majority of my fellow simulators, whatever their background, feel the same way, putting something back into the system in return for whatever help they have gained in the past – it is our National Health Service.

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doi: 10.1192/pb.31.8.316

Work-related stress

Murdoch & Eagles (*Psychiatric Bulletin*, April 2007, **31**, 128–131) list a number of stress factors identified by consultant psychiatrists. Conspicuous by its absence is any reference to stressful relationships with colleagues. Are we a profession in denial? Any internet search for information regarding causes of work-related stress (e.g. <http://www.bbc.co.uk>) will indicate that a well-recognised cause is relationships with colleagues. This was alluded to by Mackirdy (*Psychiatric Bulletin*, August 2006, **30**, 283–285). Specifically, she cautioned that specialised teams can lead to 'boundaries which can deepen into dangerous chasms unless energy is specifically directed into border diplomacy and efficiency.'

Murdoch & Eagles quite rightly suggest that given our understanding of stress it would be 'unfortunate if we do not utilise these skills to our mutual benefit in combating work-related stress.' Of course, as anyone with a basic grasp of problem-solving knows, clearly identifying the problem is key to solving it.

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doi: 10.1192/pb.31.8.316a

Goldberg and Huxley's model 27 years on

Over 25 years ago Goldberg & Huxley (1980) proposed a widely recognised pathway to psychiatric care. This model,

which has since been refined (Goldberg, 1995), predicts that 20.8 adults per 1000 population per year will be in contact with specialist mental health services. We have previously demonstrated that this model underestimated the utilisation of specialist psychiatric services in North East Edinburgh in 2003 (O'Sullivan *et al*, 2005). We decided to resurvey referrals in the same area for 2005 to attempt to replicate our findings.

We recorded all new referrals from general practitioners (GPs) to mental health services among those aged 18–64 years in our sector. This included general and specialist psychiatric services, namely clinical psychology, psychotherapy, addictions and eating disorder services. Given the emphasis on social factors in the original model, we checked for a correlation between the levels of deprivation as measured locally by the Scottish Index of Multiple Deprivation (SIMD; <http://www.scotland.gov.uk/Topics/Statistics/SIMD/Overview>) and referral rates from individual GP practices.

There were 1541 new individual referrals of those aged 18–64 years, which is equivalent to 24.6 per 1000 catchment population per year (95% CI 24–26). New referrals alone exceeded the number predicted in the model. Spearman's rank correlation coefficient between the SIMD score of individual practices and referral rate was 0.44.

In an atmosphere of continual change in the National Health Service, we urge service planners to be mindful of the gross underestimation of current referral to psychiatric services by Goldberg and Huxley's model.

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doi: 10.1192/pb.31.8.316b

Policing psychiatric units

As clinicians studying outcomes of violence by patients admitted to hospitals, the benefits of the scheme described by Mann *et al* (*Psychiatric Bulletin*, March 2007, **31**, 97–98) appear initially impressive. We are aware of the benefits



of the collaborative approach to the investigation and management of behaviours that compromise safety in National Health Service environments (Department of Health *et al*, 2006) and other measures should be welcomed. However, we have three concerns about the scheme described by Mann *et al*.

First, we are not aware of any psychiatric unit, general or of low, medium or high security, where a uniformed police officer is stationed permanently within the premises. The presence of a dedicated police officer as described by Mann *et al* would only bring further stigmatisation to those with mental illness who are generally perceived by the public as inherently violent. Second, most psychiatric units admit patients for assessment or

treatment and the permanent presence of a police officer on site would be unsettling for many. The benefits of this approach for managing violence in a minority of patients are unlikely to outweigh the problems for the majority of patients who have never been or who may never become violent.

Third, conflicts of interest would arise if the community officer who is funded by the hospital and managed as a police officer also functions to coordinate information for defence solicitors, the Crown Prosecution Service and the police. There is a risk of compromising the fairness of the legal process for patients who behaved violently in hospital. It is important for organisations to be mindful of their approach to managing violence in

order not to further stigmatise those with mental illness.

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doi: 10.1192/pb.31.8.316c

obituaries

Edmund Andrew Harvey-Smith

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The death of Eddy Harvey-Smith brings to a close the life of one of psychiatry's more colourful personalities who in the 1960s combined his love of lively debate with his fierce disapproval of the government's treatment of junior hospital doctors by chairing the Hospital Junior Staff Group Council. In this national role, Eddy fought vigorously for his colleagues to make known to the Ministry of Health and the public at large that the long hours, low pay and wretched accommodation of junior hospital doctors were unacceptable. He held the post from 1963 to 1968 and during his tenure made a massive contribution to the improvement of working conditions for doctors, an improvement that his successors were able to build on in later years.

Born in 1929, Eddy attended Latymer Upper School, where he was Vice-Captain, and after National Service in the Royal Signals, he went up to St John's College, Cambridge, where he graduated MB BChir in 1956. He gained the MRCP (Lond) in 1962. The academic aspect of life appealed less – except in mild panic when exams threatened – than friendly argument and discussion, which better suited his companionable personality and his wide-ranging mind. He was also very interested in sport, specifically soccer and squash, and it was while playing soccer for St John's College that he suffered a



serious fracture of his leg. Never one to be held back, he became a familiar figure cycling to lectures with his full leg plaster resting on the handlebars. Later he managed to borrow a motorised wheelchair, which he drove at ferocious speed through the streets of Cambridge, offering lifts to young ladies who caught his eye.

His clinical studies and early house appointments were spent at Westminster Hospital and in Kent. As registrar he held posts at Hammersmith Hospital and at Westminster Hospital before moving to the Maudsley. He passed the DPM (Lond) in 1966, the MRCPsych in 1972 and was awarded FRCPsych in 1982. In 1968 he was appointed Consultant Psychiatrist at the Croydon and Warlingham Group of Hospitals where he was to spend the next 26 years. Pursuing his political interests he was Chairman of the Psychiatric Division from 1979 to 1985. Eddy was Chairman of the Croydon District Medical Committee and on the Medical Executive Sub-Committee from 1985 to 1990, and was the Consultant Representative on the

Croydon Area Health Authority. He examined for the LRCP MRCS and for many years acted as a physician for BUPA. Indeed, he preferred to think of himself as a physician with a deep interest in psychiatry. Eddy was active in establishing the Purley Day Hospital, a development that was in the vanguard of the early movement towards community care.

Eddy always enjoyed a lively relationship with his managerial colleagues. Their prime function, in his opinion, remained that of selecting the colour of the paint. His withering wit also translated itself magnificently to a prodigious output of correspondence, which not infrequently found its way into the national press and the Secretary of State for Health's private office.

After retirement from the NHS in 1994, he continued to do locum work and see patients privately well into his seventies. It was at Hayes Grove Priory Hospital that his irreverence for authority came to the fore. His discussion groups over the lunch table, followed by a game of pool, and his tendency to see an occasional patient in the garden provoked a vocal response from management who did not care to have their hospital treated as a country club.

His later years were clouded by the onset of dementia and he was lovingly cared for at home by his daughter, Caroline and two sons, Andrew and Mark, until he had to move across the road to Kingston Hospital. 'I'm afraid it's Alzheimer's, old boy,' he observed in one of his lucid moments.

He died on 28 January 2007 and will be sorely missed.

A. J. Watson

doi: 10.1192/pb.bp.107.016667