Correspondence

Cost-effective prescribing

Singh *et al*'s[1] discussion of cost-effective prescribing is timely. Small changes in prescription writing habits can produce significant savings without noticeable change in clinical practice. A clear example is that of venlafaxine modified release which is produced in both capsule and tablet form. These are bioequivalent but vary widely in cost. It has been calculated that switching from capsule to tablet would save our local healthcare economy about £148 000 a year. The only change required of doctors would be to specify tablets on the prescription, thus ensuring the more cost-effective preparation is dispensed. The twice-daily formulation is cheaper still but would require a greater degree of change and perhaps affect adherence. Fluoxetine provides another example: fluoxetine 10 mg, a dose often used in child and adolescent mental health services, is not available in tablet form in the UK. Importing a supply can result in a single prescription cost of several hundred pounds, but specifying fluoxetine syrup ensures the cost remains less than £10.[2]

Clearly, significant savings are to be had without compromising patient care or clinical autonomy. With regular support from a vigilant chief pharmacist and medicines management committee, the vagaries of the drug tariff could be navigated and the drug budget spent more cost-effectively.

1 Singh DK, Khawaja S, Pala I, Khaja J, Krishnanu R, Walker H, et al. Awareness of the cost of psychotropic medication among doctors: a service evaluation. *Psychiatrist* 2010; **34**: 364–6.

2 British Medical Association, Royal Pharmaceutical Society of Great Britain. *British National Formulary* (issue 59). BMJ Group, Pharmaceutical Press, March 2010.

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Making a noise

Tom Burns[1] rightly draws our attention to the quiet revolution that removed continuity of care from consultant psychiatrists with the 'functional split' between in-patient and community services. Despite my initial vocal resistance to the model, now that it is established in my place of work, I would not want to go back to being the prime focus for hundreds of patients throughout their mental healthcare journey. Since the functional model was introduced, I have felt more able to do a good job. Service users may be less worried about this change than many service providers.[2]

Continuity of care through one person can reduce patient choice and lead to overdependent relationships. Second opinions are much easier to get when patients transfer between hospital and community. Care coordinators are slowly taking on continuity of care, although they sometimes struggle with the authority of consultants and managers. We can help ameliorate that by working in a cooperative and consultative style.

Some psychiatrists fear that the removal of consultant-centred continuity could help make psychiatrists redundant. Surely we need to value our expertise more than our personal carrying capacity. In future, we need to demonstrate our expert role by the good outcomes we achieve in collaboration with our teams, not simply by having lots of patients on our caseloads. We are better employed as consultants than care coordinators.

Locally, the functional model has enabled me to develop myself, my team and my service. The patient suicide rate has not increased. The more serious National Patient Safety Agency incidents (levels 3, 4 and 5) are less frequent. Patient and staff satisfaction is getting better. We could do more to address communication across the interfaces, but overall, my personal experience of the functional model has been positive.

I would prefer to improve the functional model, rather than re-combine hospital and community work. It would be satisfying to get it working well, before the next upheaval. In-patient consultants should give themselves leave in the community and community consultants should visit their colleagues in hospital. We should disentangle history taking and examination from engagement, so patients do not have to repeat their stories as they move between services – we could review our colleagues' notes with the patient rather than start afresh. It is a different way of working that allows us to be involved in the care of many service users, but as part of a team.

A US politician, Pauline R. Kezer said, 'Continuity gives us roots; change gives us branches, letting us stretch and grow and reach new heights.' There is value in continuity and value in change. The Royal College of Psychiatrists Occasional Paper, *Looking Ahead*, calls for a systematic review of models of mental healthcare using standardised outcomes.[3] However, at no point does the paper recommend that consultant psychiatrists again take on the central role of personally providing continuity of care for all patients. Instead, *Looking Ahead* explicitly values the expertise of consultant psychiatrists, our availability for rapid review and the advice we give to others (recommendation 3). That is something worth making a noise about.

1 Burns T. The dog that failed to bark. *Psychiatrist* 2010; **34**: 361–3.

2 Singhal A, Garg D, Rana AK, Naheed M. Two consultants for one patient: service users' and service providers' views on 'New Ways'. *Psychiatrist* 2010; **34**: 181–6.

3 Royal College of Psychiatrists. *Looking Ahead: Future Development of UK Mental Health Services* (Occasional Paper OP75). Royal College of Psychiatrists, 2010.

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Pessimism

Professor Burns[1] is right to draw attention to possible damaging effects of separating consultant responsibility for in-patient and out-patient care. My past experience of both overall and out-patient-only responsibility supports the points he makes. Particularly striking was distress for patients at having to get to know a new consultant and go back over long-term histories at the particularly fraught time of admission, as

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well as intractable problems of communication between consultants, and misunderstanding of the different impacts of symptoms and behaviour in the hospital and home settings.

Most fundamentally, a return to the earlier psychiatric pessimism about long-term illnesses is likely on the part of hospital consultants who deal only with those who relapse.

1 Burns T. The dog that failed to bark. *Psychiatrist* 2010; **34**: 361–3.

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The dog didn't bark because it was usefully occupied

An instinctive medical conservatism compromising the ability of psychiatry to adapt for the future has perhaps been inadvertently exposed by Professor Burns.[1] Very little of his article really stands up. The focus is on the in-patient/community 'split'. He assumes that the split has or is likely to remain at the ward door. Dysfunctional relations between egocentric psychiatrists reminiscent of the most troubled splitting and projection associated with 'psychopathology' sound like a 'mess', and would be, if they were to become established or even desired practice. No doubt there are some examples of fractured systems like this. Burns may know of hard-bitten consultant psychiatrists favouring community treatment orders (CTOs) without proper clinical consensus between colleagues; but it is not logical to condemn a movement, a 'silent revolution' or otherwise, by reference to its worst exemplars. His reasoning is reminiscent of the Dangerous Dogs Act.

Why is the role of the in-patient consultant 'obvious nonsense'? It is no such thing. The task of the in-patient consultant is to think clearly about the best interests of the patient in context: doctors should not be in-patient consultant psychiatrists unless they possess the skills to communicate with their community colleagues and hold their confidence. Burns is pessimistic about human nature and consultants in particular. He fears that they will not work well together, and culturally never have. Consider surgeons and anaesthetists. I can recall some examples of pretty odd behaviour; but out of necessity, either would accept or cope with the consequences of decisions taken by the other. Burns' attachment to sustaining individual medical autonomy across the whole process of patient care is just not helpful or necessary. He refers to the Oxford Community Treatment Order Evaluation Trial (OCTET) study highlighting the need for psychiatrists to demonstrate tolerance and collaboration as if this were an unreasonable suggestion. These are characteristics that should be developed in all doctors, but especially psychiatrists. Is that a problem?

A further misunderstanding concerns bed numbers and pressure. I would contend that acute bed numbers have reduced for a variety of reasons in recent years, one being that the introduction of crisis teams has reduced the admission rate by managing the route into acute beds and offering a preferred alternative to admission for many, thereby of necessity setting a different threshold. The in-patient mix has consequently changed. Is this an argument for re-expanding in-patient care? Surely not, the idea that we take people into hospital to dilute the experience of others is absurd. There has been pressure on beds for as long as I can recall it first hand, since 1986, long before the changes Burns contests. He rightly dislikes confusing multiple ward rounds. It is hard to fathom why this is his experience in contemporary systems, other than through eccentric implementation of change. Is something strange happening in Oxford? If there is one in-patient consultant, there will be one ward meeting, or at least if there are more, they will feature the same consultant. This contrasts with old-style sector ward rounds, several per week, each to do with a small number of patients managed in contrasting ways quite arbitrarily by disconnected consultants interacting at times only to argue about what sector someone lives in. I recollect strong views being expressed about a patient moving over the road. That particular problem should be consigned to history.

Burns alludes to a continental professional and service model. The reason for the arguable historical success of the British approach, in so far as it has been a success, is not in the location or otherwise of splits in the system. It is in the existence of a social healthcare system in the NHS and a now strained sense of collectivism. It is in Anglo-Saxon empiricism, sceptical of medical obscurantist elitism feared by Burns, and an excellent and ever-necessary defence against pomposity and hierarchy building.

Finally, it is invidious to infer increased suicide rates from studies of discharge from examples of private sector units with no interest in supported discharge, or indeed follow-up. Considering NHS in-patient services, what is the evidence that suicides have become more prevalent, let alone that there is a causal link?

Burns may overestimate the importance that individual psychiatrists should attach to their role. The flipside of 'continuity' is the patient who is shackled to a disliked consultant for years without fresh thinking and no automatic second opinion. Burns concedes potential advantages rather gamely. He acknowledges that we may all need a rest from each other, doctors and patients included. In past years this happened unofficially – let us recall without nostalgia the patients who revolved from one trainee to another for years on end without a shred of consultant continuity. They taught me a lot, but such practice is now hopefully extinct. The care programme approach (CPA) involving continuity with nurses or social workers as an alternative strand to the discussion bears mentioning. Indeed, CPA is probably the key to consultants having a consultant role rather than acting as a kind of parallel, ghettoised general practitioner for people with enduring psychosis.

People do, of course, need stability in their key relationships. I am not at all sure that psychiatrists should appropriate a role, which properly lies 'out there'; our difficult job is to try to help make that a reality and then quietly withdraw. Good psychiatrists are quite capable of sharing thoughts and plans, do not unilaterally and thoughtlessly impose directives on their colleagues, are considerate of their own limitations and ultimately the very conditional nature of the impact that we personally should aim to have on peoples' lives. When the water closes over us as if we were never there, we succeed. We have to see ourselves as less linear and more systemic, less unique and more integrated, and act humanely mindful of all,

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