

cooperation between Health and Home Affairs ministries, with the former providing the medical manpower, the latter the facilities. There is no Hospital Order in Singapore and indeed the Judiciary would argue that there is no need for it.

I agree with Ruth McCutcheon about overseas training experience at senior registrar level (a point to consider for the future specialist registrar grade). Piachaud (1992) suggests forging links with a view to establishing a list of approved overseas centres for the purpose of higher psychiatric training. The recent establishment of the Institute of Mental Health in Singapore heralds an important move towards more research and development; the service would certainly welcome a partnership in this endeavour.

As a possible training centre, Singapore offers a unique blend of East and West, continues to use English as the first language, and has highly advanced information technology. The logical first step would be an exchange exercise in the sub-specialities and I invite the Joint Committee of Higher Psychiatric Training (JCHPT) to consider this.

PIACHAUD J. (1992) Overseas doctors—training ethos. (Letter). *Psychiatric Bulletin*, 16, 666.  
ROBERTSON, J. R., HALSTEAD, S., TAN, T & LAWRENCE, J. (1992) Psychiatric training, Singapore. *Psychiatric Bulletin*, 16, 36–38.

JEYABALA BALAKRISHNA, St George's Hospital, London SW17 0QT

Sir: Dr Balakrishna supports the value of overseas training experience for higher psychiatric trainees and suggests a two-way exchange.

The approval of higher training overseas is not entirely straightforward, since there is no exact equivalent in other countries of this grade, with its expectations of training and supervision rather than purely service. In many countries also the differentiation of psychiatry into six specialities (general adult psychiatry, old age, child and adolescent psychiatry, psychotherapy, forensic, mental handicap) is not as well developed as in the UK. However the JCHPT recognises the value of overseas experience and one year of the minimum three year higher training period spent overseas can be approved for higher training. Because of the differences in training

and the impracticality of inspecting overseas placements, this is currently required to be by outposting and approval from a higher training scheme in this country. Similar recognition will apply to higher training in the new specialist registrar grade.

The JCHPT is also exploring, with the College, a pilot scheme to enable overseas psychiatrists to come to this country for higher training.

E. S. PAYKEL, *Chairman, Joint Committee on Higher Psychiatric Training, Royal College of Psychiatrists*

### Lithium prescribing and monitoring in general practice

Sir: The letter from Dr A. D. Armond (*Psychiatric Bulletin*, February 1995, 19, 117) concerning lithium prescribing and monitoring in general practice has been widely reported in the general practice press; the views expressed on management cannot pass unchallenged. Dr Armond suggests that lithium prophylaxis should not take place in general practice even when the patient is stabilised, and that the complex pharmacology of lithium and the variability of supervision make general practitioners (GPs) unsuitable to administer this drug. This view correlates with the perception among some psychiatrists that GPs are "particularly liable to make inappropriate choice of drug and dose" (Brown, 1993).

It is unusual for a GP to initiate treatment with lithium. Those patients with severe affective symptoms requiring lithium will not have responded adequately to neuroleptic or antidepressant treatment. The help of a psychiatrist is then often needed. Some patients, however, refuse to see a psychiatrist because of perceived stigma associated with a psychiatric referral. Therefore, I have started some patients on lithium for its mood stabilising effects, and also as adjunctive treatment for depression. Dr Armond's anxieties about the interaction between lithium and other drugs has been largely obviated by the development of computer programmes in general practice which will warn the doctor, at the time of prescribing, about possible interactions.

Lithium undoubtedly needs to be monitored carefully within the community. Psychiatrists may not be aware that the trend for monitoring chronic disease is to involve primary care where possible, and there are drugs of equal

complexity that GPs deal with, including insulin, cytotoxic drugs, gold injections and steroids: other consultants do not share Dr Armond's anxieties.

Lithium has an important role in the management of affective disorders (Cowen, 1988; Gelder *et al*, 1989), particularly in prevention of recurrence of mania and depression. There is no doubt that the use of lithium does need to be monitored but this is quite easy in general practice, and each doctor should have a plan for monitoring drug levels. My practice is to do levels three-monthly, with an annual check on thyroid and renal function, but some authors (Kehoe & Marder, 1992) feel that this policy is too strict. We need to develop and improve good practice (Aronson & Reynolds, 1992) so that as many people as possible can be treated in the community rather than attending hospitals or local mental health units for blood testing. This issue is not being driven by fund-holding but by good clinical practice.

- ARONSON, J. K. & REYNOLDS, D. J. M. (1992) Lithium. *British Medical Journal*, **305**, 1273–1276.
- BROWN, P. (1993) Ethical aspects in drug treatment. In *Psychiatric Ethics* (2nd ed.) (eds S. Bloch and P. Chodoff) Oxford:Oxford University Press.
- COWEN, P. J. (1988) Depression resistant to tricyclic antidepressants. *British Medical Journal*, **297**, 435.
- GELDER, M., GATH, D. & MAYOU, R. (1989) Drugs and other physical treatments. In *Oxford Textbook of Psychiatry* (2nd Ed). Oxford:Oxford University Press.
- KEHOE, R. F. & MANDER, A. J. (1992) Lithium treatment: prescribing and monitoring habits in hospital and general practice. *British Medical Journal*, **304**, 552–554.

DOMINIC H. R. FAUX, 'Albion House', *Albion Street, Brierley Hill, West Midlands DY5 3EE*

Sir: I am glad to reply to Dr D. Faux's letter about general practitioners (GPs) prescribing lithium. The *British National Formulary*, some computer programmes in general practice and several psychiatrists, including myself, (*Prescriber*, 1991, **38**, 81–83) have apparently not been very successful in contributing to the safety of lithium prophylaxis in general practice.

Of 1250 consecutive lithium estimations over several months in 1994 in our borough of 305 000 population, 5 out of the 6 levels above 1.2 mmol/l were found in patients in GPs' care only, even though the vast majority of patients on lithium were in consultant care.

In my original letter, 'General Practitioners and Lithium', *Psychiatric Bulletin*, **19**, 117) research in Edinburgh was quoted as showing that where GPs controlled lithium prophylaxis with advice and reminders from the central hospital, the admission rate for mania rose enormously instead of falling by over 70% as in my clinic and the drop-out rate was 10 times that found in my clinic.

Now, Dr S. Noblett's audit in Macclesfield reveals that "the level of monitoring of serum lithium, renal and thyroid function, is far superior in those patients who attend the clinic nurse in the out-patient department compared to those monitored by the community psychiatric nurse or general practitioner in the community"; and default or non-compliance bring about an immediate follow up.

There is no doubt that a GP can monitor lithium maintenance satisfactorily if prepared to become well informed and to remain up to date, and if it is fully realised that such lithium monitoring is only one part of a much bigger project to keep a manic-depressive patient as well as possible—without which, lithium does more harm than good.

A. D. ARMOND (*Former general practitioner*), *Consultant Psychiatrist, Bushey Fields Hospital, Bushey Fields Road, Dudley, West Midlands DY1 2LZ*

### Consent, decision making and Common Law

Sir: We were interested to read 'The emergency treatment of overdose: a problem of consent to treatment' by Hardie *et al* (*Psychiatric Bulletin*, January 1995, **19**, 7–9). We welcomed the highlighting of this legally and ethically important topic. However, we have concerns about the methodology and the finding that "there was no clear consensus as to the correct choice of action".

The method involved forced choice responses regarding the management of a vignette. It is doubtful whether answers about a single vignette, particularly given the limited range of choices, adequately reflect clinical practice. Importantly the issue of allowing patients to leave without treatment was not addressed, this being a critical issue in reality. Of the responses available, 75% entailed forced treatment of the patient at some time. Thus, there was a bias towards treatment in the