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# The Psychiatrist

FORMERLY THE PSYCHIATRIC BULLETIN

## Can making physical healthcare policies more readable improve healthcare standards?

Waqas A. Khokhar, Graeme Tosh and Andrew Clifton

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## Correspondence

### National DNA Database and psychiatric patients

The advent of DNA analysis as a powerful tool for crime detection has led to the creation of England and Wales's National DNA Database (NDNAD). This is one of the world's largest databases of DNA information, storing profiles of nearly 5 million individuals.<sup>1</sup> We write to raise a concern about the potential impact of this database on people with mental disorders.

The NDNAD has long been the subject of scrutiny and criticism with regard to how DNA profiles are collected and retained and from whom. This is because the current regulations on DNA profile collection mean that the NDNAD includes DNA profiles of a large number of people who have never been convicted of any crime. These DNA profiles are currently retained indefinitely. This practice was challenged in the European Court of Human Rights who found England and Wales to be in breach of the European Convention on Human Rights. In light of this, both the current and previous UK governments have signalled their intention to enact reform but as yet there has been no change in legislation.

Some groups, including young Black men, are known to be overrepresented on the database<sup>2</sup> and we are concerned that those with mental health problems, a vulnerable group of people, are similarly affected. This issue has been largely unexamined and there are no estimates for the number of people with mental disorders on the NDNAD. However, in 2008, 9% of mental health in-patients were admitted via the criminal justice system.<sup>3</sup> Furthermore, studies of individuals in prison and on remand have concluded that mental disorder is extremely common in these populations, with respective rates of 90% and 63%.<sup>4,5</sup> It would be surprising if the population of those on the NDNAD were not to broadly reflect this state of affairs.

It is arguable that a person with mental health problems who has a profile on the NDNAD despite being without criminal conviction is not only disadvantaged but also criminalised. This is a potentially unhelpful outcome for the process of engagement and recovery. We have concerns about how some patients come to be on this database. Patients arrested as a direct result of their mental state may find themselves on the database despite being diverted into mental health services without charge. Given that police powers allow that reasonable force may be used to take a DNA sample without consent, a disturbed and oppositional patient may be injured in the process. There is also lack of any formal pathway for removal from the NDNAD, which is at present difficult to navigate.

The new UK coalition government has undertaken to adopt the current Scottish model whereby DNA profiles of those arrested but not convicted are retained for 6 years only. DNA profiles of those convicted will be kept indefinitely as before. This reform would go some way to addressing our concerns.

We would welcome a debate among clinicians on the issues surrounding mental health patients and the National DNA Database.

### Declaration of interest

Both authors are members of campaign groups Liberty and No2id. Neither of these organisations was involved with this letter at any stage.

- 1 National Police Improvement Agency. *National DNA Database: Annual Report 2007–09*. NPIA, 2009 (<http://www.npia.police.uk/en/docs/NDNAD07-09-LR.pdf>).
- 2 Rt Hon Baroness Scotland of Asthal QC, Minister for Criminal Justice and Offender Management. *Minutes of Evidence 13 March 2007 (Q653)*. House of Commons, 2007 (<http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhaff/181/7031305.htm>).
- 3 Commission for Healthcare Audit and Inspection. *Count Me In 2008: Results of the 2008 National Census of Inpatients in Mental Health and Learning Disability services in England and Wales*. Commission for Healthcare Audit and Inspection, 2008. ([http://www.cqc.org.uk/\\_db/\\_documents/Count\\_me\\_in\\_census\\_2008\\_Results\\_of\\_the\\_national\\_census\\_of\\_inpatients\\_in\\_mental\\_health\\_and\\_learning\\_disability\\_services.pdf](http://www.cqc.org.uk/_db/_documents/Count_me_in_census_2008_Results_of_the_national_census_of_inpatients_in_mental_health_and_learning_disability_services.pdf)).
- 4 Singleton N, Meltzer H, Gatward R. *Psychiatric Morbidity among Prisoners in England and Wales (Office for National Statistics)*. TSO (The Stationery Office), 1998.
- 5 Maden A, Taylor CJA, Brooke D, Gunn J. *Mental Disorder in Remand Prisoners*. Home Office, 1995.

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### Not with a bark

It was a great relief to read Professor Burns' editorial<sup>1</sup> concerning the loud silence around the separation of in-patient and out-patient consultant care. The dogs have certainly not barked, not even growled.

This is the largest single change in clinical practice in my working life and appears to go against the grain of other developments. There is no evidence base for it, nor could it be described as patient-centred. The past two decades of enquiries have often pointed to discontinuity of care and communication problems as potential risks, and both are likely consequences of 'functionalisation'. There may well be positive outcomes with regard to in-patient care, but I believe these could have been achieved without reducing the quality of community care.

Consultants are an expensive resource and I wonder whether the future will see reduced numbers of senior medical professionals working mainly as psychopharmacologists with in-patients, whereas the community service is provided by other disciplines alongside primary care. Is this the way psychiatry ends, not with a bark but a whimper?

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

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doi: 10.1192/pb.34.11.496a

## A plea for re-illusionment

Burns' *cri de coeur*<sup>1</sup> about the thoughtless severing of in-patients from community responsibility will strike a chord in colleagues of his demographic. Our generation saw the special contribution of the consultant psychiatrist as encompassing continuity of care across time and space in ways unique to our discipline. We hoped to see our patients holistically through the vicissitudes of illness, recovery, health and relapse, creating, when things went well enough, a deep life-enhancing mutual knowledge. Yes, we were spread thin, the workload was tough at times, and Jacks of all trades (psychotherapy, group and systemic therapy, psychopharmacology) must sometimes give way to master-craftsmen. But has psychiatry traded an easier life for a diminishing and less satisfying role? How long before an impoverished state finds our profession largely redundant? Are we in danger of becoming our own grave-diggers? Or is all this merely nostalgia seasoned with generational grumpiness? Re-illusionment please!

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

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## Because of the mental disorder . . .

Short-term detention for mental disorder under the Mental Health (Care and Treatment) (Scotland) Act 2003 requires an approved medical practitioner to certify that a condition specified in Section 44(4)(b) of the Act is met: namely that 'because of the mental disorder, the patient's ability to make decisions about the provision of medical treatment is significantly impaired'.

Many practising clinicians will realise that there are myriad reasons why patients with mental disorder will not, for example, take necessary medication. These include family attitudes and previous adverse experiences, as well as factors caused by the mental disorder itself such as delusional beliefs. Clinical discussions surrounding a recent tribunal I attended have crystallised this for me.

Was it really the view of the Scottish Parliament that a patient who refuses medication for a severe psychotic exacerbation on grounds not actually caused by this illness should remain untreated?

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doi: 10.1192/pb.34.11.497a

## How many is too many?

I write in response to the letter from Neelam & Williams.<sup>1</sup> The authors are responding to the paper by Singhal *et al*,<sup>2</sup> who elicited the views of service users and providers with regard to separate consultant teams for in-patients and out-patients. Neelam & Williams described the use of a third team – the crisis resolution home treatment team (CRHTT), saying that this team performs a vital role in the period between discharge from the in-patient team and the patient being sufficiently well for safe and effective transfer into the community mental health team (CMHT).

The most consistent theme that emerged from Singhal *et al*'s study was the difficulties in continuity of care and maintaining the therapeutic relationship when patients moved from the in-patient to the CMHT. It seems rather bizarre that Neelam & Williams contend that the problem can be ameliorated by introducing yet a third team into the discontinuity between in-patient and out-patient care. Neelam & Williams note that patients often asked to remain permanently under the care of the CRHTT and it seems probable that these patients are seeking a return to the more traditional model of continuity of care from one single team.

I write as a trainee psychiatrist who has worked only in generic psychiatric teams that care for patients whether they are in-patients or living in the community. In my experience, these teams provide high-quality care and encounter no difficulties in continuity and maintaining therapeutic relationships. Perhaps an advocate of New Ways of Working<sup>3</sup> could explain to me the advantages of an ever-increasing 'specialist team' approach as opposed to the 'one patient, one team' model?

1 Neelam K, Williams F. Three consultants for one patient. *Psychiatrist* 2010; **34**: 357.

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 Department of Health. *Mental Health: New Ways of Working for Everyone*. Department of Health, 2007.

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## Psychiatrists behaving badly?

The reason why many of us choose psychiatry as our specialty is that we like the human touch of medicine. To a large extent this is our strongest attribute, but as O'Leary *et al*<sup>1</sup> have demonstrated, quite perversely it is this affinity that also leads to our failing in the areas we should excel in, namely relationships with colleagues and patients as well as good clinical practice. The implications of the numbers of psychiatrists being referred to the National Clinical Assessment Service (NCAS) should not be underestimated not least to themselves but also to mental services as a whole. Coupled with the recruitment problems in junior training posts and the relative inability to make our specialty attractive to medical undergraduates,<sup>2</sup> we are likely to store further problems of recruitment to consultant posts, something that has dogged our profession for many decades but none more so than in the 1980s and 1990s. Elsewhere in the journal, Burns articulates his concerns on how the consultant's role lacks definition,<sup>3</sup> a factor that might well influence our performance and our attitude to others, as well as others' to us. My sense is that we need some creative thinking around how we might promote our specialty, while simultaneously ensuring that our colleagues are supported in the right manner during their stressful years of practice. In this regard, O'Leary *et al*'s call for the College to review the continuing professional development (CPD) programme is not inappropriate, but as the CPD Committee has just set out a new policy<sup>4</sup> it could be some time before the next policy comes round. There is evidence

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.<sup>5</sup> 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.

- 1 O'Leary D, McAvoy P, Wilson J. Performance concerns in psychiatrists referred to the National Clinical Assessment Service. *Psychiatrist* 2010; **34**: 371–5.
- 2 Burns T. The dog that failed to bark. *Psychiatrist* 2010; **34**: 361–3.
- 3 BMA Board of Medical Education. Selection for Specialty Training. BMA, 2006 ([http://www.bma.org.uk/images/SelectionSpecialtyTraining\\_tcm41-147106.pdf](http://www.bma.org.uk/images/SelectionSpecialtyTraining_tcm41-147106.pdf) ).
- 4 Royal College of Psychiatrists. *Good Psychiatric Practice: Continuing Professional Development (2nd edn)*. College Report CR157. Royal College of Psychiatrists, 2010.
- 5 Bamrah JS, Bhugra D. CPD and recertification: improving patient outcomes through focused learning. *Adv Psychiatr Treat* 2009; **15**: 2–6.

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#### Routine outcome measures in liaison psychiatry

Jacobs & Moran,<sup>1</sup> 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;<sup>2</sup> 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.<sup>3</sup> 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.<sup>4</sup>

- 1 Jacobs R, Moran V. Uptake of mandatory outcome measures in mental health services. *Psychiatrist* 2010; **34**: 338–43.
- 2 Organisation for Economic Co-operation and Development. *Health at a Glance: OECD Indicators*. OECD, 2007.
- 3 de Albuquerque Citero V, de Araujo Andreoli PB, Nogueira-Martins LA, Andreoli SB. New potential clinical indicators of consultation-liaison psychiatry's effectiveness in Brazilian general hospitals. *Psychosomatics* 2008; **49**: 29–38.
- 4 Palmer L, Dupin M, Hinchcliffe G, McGeorge M (eds). *Quality Standards for Liaison Psychiatry Services*. Royal College of Psychiatrists, 2009 (<http://www.rcpsych.ac.uk/pdf/PLAN%20Standards%20First%20Edition%20Sep2009.pdf>).

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#### Women in academic psychiatry: view from India

Dutta *et al*<sup>1</sup> 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.<sup>2</sup> 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

major chunk of women's contributions to the *Indian Journal of Psychiatry*. Reviews, invited articles, presidential addresses, editorials, commentaries, orations and critiques by women authors in the journal are negligible.

No woman psychiatrist acts as advisor to the Government of India on policy matters related to mental health in general or in relation to women.<sup>3</sup>

As far as looking after the specific needs related to their family-related roles, there are no guidelines for pregnancy and maternity leave for women postgraduate students in the country. If a woman joins a government job, there is a provision for maternity leave, but this often is not available for postgraduate students. Few hospitals or medical colleges provide reliable on-site day care and school-based childcare is not available when children are older. On discontinuation of a job for family building or other reasons, options for career revival after a certain period are presently unavailable because of age restrictions.

There is no association of women psychiatrists at regional or national level.<sup>2</sup> Unlike high-income countries, where specific needs, aspirations, areas of interest, monetary incentives, working styles, characteristics and other issues related to women psychiatrists have been studied and attempts have been made to address these, there is negligible research in this area in low-income countries. Moreover, women have a negligible role in policy-making in psychiatry.

Currently, there is no system addressing the specific issues related to women doctors as a whole in India and other neighbouring countries on the Indian subcontinent.<sup>2</sup>

- 1 Dutta R, Hawkes SL, Iversen AC, Howard L. Women in academic psychiatry. *Psychiatrist* 2010; **34**: 313–7.
- 2 Sood M, Chadda RK. Women in psychiatry: a view from the Indian subcontinent. *Indian J Psychiatry* 2009; **51**: 199–201.
- 3 Sood M, Chadda RK. Women psychiatrists in India: a reflection of their contributions. *Indian J Psychiatry* 2010; **52**: 396–401.

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### Is the assessed capacity increased with the seriousness of what is at stake?

In *Re T*<sup>1,2</sup> the Court of Appeal had to consider the case of an adult Jehovah's Witness who refused treatment. A pregnant woman was involved in a car accident and, after speaking with her mother, signed a form of refusal of blood transfusion. After the delivery of a stillborn baby, her condition deteriorated, therefore a Court order was obtained in order to legalise a blood transfusion on the grounds that it was in the woman's best interest. In this case the Court of Appeal addressed the question related to capacity, life-threatening situation and right to refuse a medical treatment, particularly in relation to the degree of risk involved in a particular decision: 'What matters is that the doctor should consider whether at that time he had a capacity which was commensurate with the gravity of the decision. The more serious the decision, the greater the capacity required.' It is interesting to consider, as pointed out by Buchanan,<sup>3</sup> 'What principles then govern the practice, described in *Re T*, whereby the level of capacity required for competence rises in proportion to what is at stake?' In other

terms, is the assessed capacity required for legal competence increased with the seriousness of what is at stake? Perhaps the assessment of capacity has to consider the importance, the risk and the gravity of the decision that the patient has to make. Following this train of thought, maybe different standards of competence are needed in order to ensure that genuine choices are being made.

Buchanan & Brock<sup>4</sup> were more inclined to sustain this view in terms of capacity, whereas Culvert & Gert<sup>5</sup> and Wicclair<sup>6</sup> found the idea of different standards of competence more paternalistic-oriented. Culvert & Gert argued that the capacity related to the degree of risk was against the principle of 'symmetrical competence' and pointed out that the change of external risk can potentially change the status of a person from competent to incompetent, 'a fact inconsistent with the idea that competence is a genuine attribute of a person'.

- 1 *Re T (adult) (refusal of medical treatment)* [1992] 4 All ER 649, (1992) 9 BMLR 46, CA.
- 2 *Re T (adult) (refusal of medical treatment)* [1992] 4 All ER 649.
- 3 Buchanan A. Mental capacity, legal competence and consent to treatment. *J R Soc Med* 2004; **97**: 415–20.
- 4 Buchanan AE, Brock DW. *Deciding for Others: The Ethics of Surrogate Decision Making*. Cambridge University Press, 1989.
- 5 Culvert C, Gert B. The inadequacy of incompetence. *Milbank Q* 1990; **68**: 619–43.
- 6 Wicclair M. Patient decision-making capacity and risk. *Bioethics* 1991; **5**: 91–104.

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### Inconsistencies in Section 136 assessments

Liz Tate<sup>1</sup> rightfully mentioned that there are junior trainees attending to the Section 136 assessments, despite clear guidance in the Mental Health Act Code of Practice that it should be done by Section 12(2)-approved doctors. Further to that, the Code states that a reason should be documented for divulging from the aforementioned practice. In most places this practice of assessments by a non-Section 12(2)-approved doctor is a protocol and a norm.

Every directorate and trust has its own local policies, keeping the Code of Practice as standard. For the formulation of a local policy, representatives from multiple agencies such as police, accident and emergency departments, ambulance services, Social Services and mental health services formulate guidelines for the fluidity of the process of Section 136 assessments. Timescales are set for the completion of these assessments and are regularly reviewed.

There are provisions for middle tier or consultant cover to facilitate the Section 136 assessments. Despite these arrangements, there are units where the attendance of non-Section 12(2)-approved doctors is the first port of call for such assessment; after a detailed history has been taken from the patient, the Section 12(2)-approved doctor is contacted and the assessment completed. Furthermore, it is known that there are places where non-Section 12(2)-approved doctors discharge patients after having discussions over the telephone with a Section 12(2)-approved doctor. It has also been found

that there are times when patients are admitted to in-patient beds under Section 136 for more than 48 hours, for example because the concerned Section 12(2)-approved doctor is reluctant to come out to complete the Section 136 assessment out of hours. There are few places where the Code of Practice is scrupulously followed and Section 12(2)-approved doctors are the first port of contact.

It makes you wonder that despite being a part of the legal system, Section 136 is very poorly managed as compared with the other sections of the Mental Health Act. There is no unitary form for Section 136 assessment documentation and no accountability for the assessments and detention of persons on Section 136. The time is right to make amends for this varied practice and for measures to be taken to get it right.

1 Tate L. Inexperienced trainees doing more Section 136 assessments (e-letter). *Psychiatrist* 2010; 26 July (<http://pb.rcpsych.org/cgi/eletters/34/7/268#10147>).

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### Can making physical healthcare policies more readable improve healthcare standards?

Gonzalez *et al*<sup>1</sup> have pointed out an interesting omission in the form of poor physical healthcare monitoring in routine psychiatric practice and there is evidence from various local and national audits<sup>2,3</sup> that it is not restricted to just the out-patient settings. The authors have also rightly picked up on key barriers to the implementation of physical healthcare monitoring in psychiatric settings, namely unclear responsibilities, competing demands on limited resources and liability issues. We believe that, for a start, this can be addressed by having readable, succinct and unambiguous physical healthcare policies.

Tosh *et al*<sup>4</sup> examined the physical healthcare policy documents of the three mental healthcare trusts in the north sector of the East Midlands Strategic Healthcare Authority in detail. We found significant disparities between the policies in terms of size, readability, external references and reading cost. All the policies incorporated vague language in their directives and none could be read swiftly. It is only fair to make a reasonable observation here that if a policy cannot be accessed or is unfocused or vague, then it will be ignored.

Multiple layers of guidance and variation between deaneries, trusts and teams also complicate the situation. This leads to confusion and lack of confidence between team members as to which policy to follow. The result is a huge wastage of money from duplication and undermining of the ability of the policy to deliver its objectives.

A collaborative effort at the national level could produce a simple, clear and succinct policy for physical healthcare of people with serious mental illness. We believe that the Royal

College of Psychiatrists is in a unique position to take a lead on this very important aspect of patient health and well-being. There are already themes emerging from research that it is an area which is very important to the patients, carers and their families alike.<sup>5</sup> A clear national policy statement from the College should dispel current confusion, policy fatigue and waste.

1 Gonzalez C, Ahammed N, Fisher R. Improving physical health monitoring for out-patients on antipsychotic medication. *Psychiatrist* 2010; **34**: 91–4.

2 Abbasi Y. Improving physical health monitoring in psychiatry – change we need? *Psychiatrist* 2010; **34**: 210–1.

3 Barnes TR, Paton C, Cavanagh MR, Hancock E, Taylor DM. A UK audit of screening for the metabolic side effects of antipsychotics in community patients. *Schizophr Bull* 2007; **33**: 1397–403.

4 Tosh G, Clifton A, Adams CE. Physical health care policies in mental health trusts in the North East Midlands (UK). *Mental Health Rev J* 2010; **15**: 15–20.

5 McCrae J. Physical health concerns of the patient, the family and the carers. *Eur Psychiatry* 2010; **25** (suppl 2): 34–6.

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### A fishy business

Has anyone else noticed that the epigram at the start of this paper<sup>1</sup> is incorrectly attributed? It does not express a Taoist idea, and is not the kind of thing Lao Tsu would have written. Unfortunately, I have not been able to locate the original source. For example, it does not appear in the *Oxford Dictionary of Quotations* (where 20 reliable quotes from Lao Tsu are listed). At least one website also wrongly lists Lao Tsu as the author, and another refers to the quotation as a Chinese proverb, but a third calls it an English proverb. (I have been wondering if the original author might actually have been contemporary, an Oxfam official for instance.) I have checked again through Lao Tsu's *Tao Te Ching*, the only work of his that survives. 'Give a man a fish . . .' definitely does not appear. Indeed, the only (sole) reference to fish comes in Chapter 60: 'Governing a large country is like frying a small fish; you spoil it if you poke it around too much'. It occurs to me that a number of politicians, including particularly the Secretary of State for Health, might wisely take note of that point. What are the chances of them taking the bait?

1 Hill L, Roberts G, Igbrude W. Experience of support time and recovery workers in promoting WRAP. *Psychiatrist* 2010; **34**: 279–84.

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