Underdiagnosis of personality disorder reflects a tendency to concentrate on presenting symptoms, ignorance of criteria for making the diagnosis and of its impact on the prognosis of coexisting conditions, and pessimism about its treatment. Many patients suffering from personality disorder have little tolerance of psychic or physical pain. They attempt to deal with such pain or to bolster poor self esteem by adopting various maladaptive strategies such as overdose, other self harm, eating disorder, alcohol or drug misuse, antisocial activity, or promiscuity.

Patients with personality disorder thus tend to present for help in crisis, often dramatically. As a result of childhood experiences (for example, sexual abuse) they mistrust figures in authority, including doctors and nurses. This mistrust is rooted in a profoundly low self esteem, and illness is perceived as being deserved. Help provided is perceived as not being merited, and therefore engagement in and compliance with treatment are impaired.

The goal of treatment is to convert the person who acts to relieve psychic stress into a person who thinks and feels.¹ To achieve this, however, patients need to be meaningfully engaged in treatment, and doctors therefore need to be informed about personality disorder. Personality disorder in one generation can produce it in the next through poor parental supervision, parental uninvolvedness, and parental criminality and aggressiveness.⁴

There are thus important educational targets, both within and outside psychiatry, to increase the recognition of personality disorder, to facilitate the learning of skills to engage people with personality disorder meaningfully, and to develop a range of treatment resources for these people. The content of *The Health of the Nation* should reflect the importance of this group of patients for the sake of the nation's greater health.

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Appointments committees

SIR,—Nick Evans's proposal for changing the present system of consultant appointments has much to commend it.¹ I have recently been able to compare the system for appointing a consultant in the NHS with that used to appoint a head of a private school of which I am a governor. The NHS post is of course tenured (that is, the holder is virtually unsackable) and the school post is not; the initial salaries are similar.

The NHS appointment committee began with a homily from the chairperson about equal opportunities, and the usual banal series of questions to the candidates followed from the large interview committee. The candidates interviewed had all been to visit the hospital in question and had no doubt engaged in the sort of circus that Evans so aptly described. We were seeing the candidates under the worst possible conditions for what for them was probably the most important move of their careers. Time will tell if the "right" person was chosen, but he (yes, it was a he) now has a job for life.

The process of selecting the school head was very different. A headhunter was used to draw up a list of possible candidates. The governors met

to consider the applications, and a shortlist of two was drawn up. These two were then seen at some length by every governor; in my case three governors met together, seeing each candidate for about an hour and a half. Extensive references were acquired by the headhunter; even the services of a graphologist were used. I had previously viewed such people with suspicion: to me they smacked of fortune tellers and mumbo jumbo. The graphologist's assessment of the two candidates was remarkably perceptive, not only mirroring almost exactly our own assessment but confounding one candidate's husband by its accuracy. When the interviews were complete the governors met (about two weeks later) and after some two hours' discussion the choice was made.

Of course, the reputation of a school depends on its head, but so does the reputation of a department and a hospital depend on its consultant staff. There has to be a better way of appointing consultants than the present system; reform is long overdue.

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- 1 Evans N. There must be a better way. *BMJ* 1991;303:1483. (7 December.)

SIR,—I welcome Nick Evans's plea for a reassessment of selection procedures for consultants.¹ I have served as a lay chairman of several consultant and senior registrar advisory appointments committees. I also have extensive experience of interviewing in other parts of the public sector, including the extended interviews used to select high flying civil servants.

The procedures traditional in medical selection seem not to draw on good personnel practice elsewhere and make poor use of the time of assessors and candidates alike. As they draw principally on professional custom, the BMA could do its members a service by setting up a group (including outside expertise) to undertake a review.

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Nursing comes of age

SIR,—We were interested to learn of Mr Robert Sims's private member's bill, which seeks to legislate in favour of prescribing by nurses.¹ The Advisory Group on Nurse Prescribing accepted this idea in respect of health visitors and other "specialist nurses," who would be permitted "initial prescribing" powers from a limited nurse formulary.² The advisory group concluded that other groups, such as community psychiatric nurses, should be permitted to alter the timing and dose of drugs that had already been prescribed, within a patient specific protocol. If community psychiatric nurses became "initial prescribers," the committee believed, it might compromise their dual responsibility to hospital based and primary health teams and invite untoward pressure to prescribe from patients with whom a close relationship had been formed.

In a study we interviewed 10 general practitioners, 10 community psychiatric nurses, and four senior psychiatrists from north Clwyd about community psychiatric nurses prescribing psychotropic drugs.³ The community psychiatric nurses reported frequent requests from patients for advice about adverse effects and the duration of drug treatment. Eight community psychiatric nurses said that they were asked by general practitioners

for advice, although only one general practitioner admitted to requesting such help. One community psychiatric nurse had received post-basic training in clinical psychopharmacology, but most updated their knowledge from the *British National Formulary*, pharmaceutical representatives, and nursing journals. Seven general practitioners supported prescribing by community psychiatric nurses in principle. Three general practitioners, two community psychiatric nurses, and two psychiatrists disagreed with prescribing by community psychiatric nurses on the grounds that the nurses lacked knowledge of general medicine and therapeutics. Two psychiatrists viewed the nurses as having a limited role in prescribing.

Our study indicated awareness of the changing role of community psychiatric nurses among the nurses themselves, general practitioners, and psychiatrists. Opinion on the issue of prescribing by nurses remained divided. It could certainly save doctors' time and provide rapid titration of drug treatment to individuals' needs, but training courses in therapeutics would have to be established for the nurses concerned. Issues of clinical responsibility in the event of litigation would have to be addressed and a method of monitoring alterations in treatment devised for circumstances in which they could be made by several professionals—perhaps through patients holding their own records, as is now the case in some clinics.

In the United States many health professionals have limited drug prescribing privileges. Indeed, the American Department of Defense is training psychologists to be able to prescribe four drugs used in psychiatry.⁴ If psychologists, with appropriate training, may be permitted to prescribe drugs why cannot community psychiatric nurses, who already have an extensive influence on patients' management?

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Disposal of clinical waste

SIR,—We fully endorse Alison Walker's comments about the potential risks of clinical waste and the need to adopt a "universal safe practice."¹ Currently, incineration is the commonest method of disposing of clinical waste and is likely to remain so. The problem is where this waste is to be incinerated.

Health authorities are required to take the necessary steps to ensure full compliance with the Environmental Protection Act.² In Cheshire a report by the county waste disposal officer highlighted the need for substantial and costly refurbishment of all the existing hospital incinerators to comply with the proposed interim emission standards to be implemented this year.³ Commercial waste disposal companies in Cheshire will have sufficient capacity to take up all the extra waste currently dealt with on hospital sites, but the incinerators they use will not necessarily comply with the regulations ultimately to be enforced (personal communications from the Cheshire County Council Waste Regulations Authority). This may well cause problems for health care practitioners in hospitals and in the community who generate clinical waste (groups A to D in-