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

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-

clusive, as defined by health services management documents¹). It is also likely to lead to an increase in the cost of disposing of clinical waste in hospitals. This should encourage a review of the types of waste disposed of as clinical waste to discourage inappropriate use of yellow bags—for example, in offices for disposing of confidential documents.

With the shift from hospital care to nursing home care for certain categories of patients it is no longer acceptable for clinical waste from nursing homes to be mixed with general household waste.

Problems will also arise with the disposal of pharmaceutical waste. Hospitals have always been expected to make adequate provision for the safe disposal of cytotoxic agents, volatile solvents, and unwanted or out of date medicines. Hospitals will now be subject to prosecution if infringements occur. In community pharmacies "special waste" includes all prescription only medicines.⁶ Strict interpretation and the need for a detailed consignment note for the future disposal of these items mean that local "DUMP" campaigns, in which members of the public are invited to surrender their unwanted medicines, may be at risk. DUMP campaigns have been successful in collecting not only unwanted medicines but also other toxic chemicals—for example, weed killers—and every effort should be made to ensure that they continue.

Initiatives must be put in place locally to ensure compliance with the new Environmental Protection Act, though there is understandable concern over the availability of adequate incineration facilities and the likely escalation of costs for disposing of clinical waste.

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Randomised clinical trials in general practice

SIR,—In their comment on G Tognoni and colleagues' paper on randomised clinical trials in general practice¹ Viv Peto and Angela Coulter suggest that it is counterproductive to rely on financial incentives to persuade general practitioners to participate in research.² We do not entirely agree. General practitioners have little time and inclination to undertake extra work. This is especially so when such work does not give financial, intellectual, or professional satisfaction. If the experiences of Tognoni and colleagues and Peto and Coulter show us anything it is that failure lies ahead when these basic requirements are not addressed. A multicentre research project for which a general practitioner is asked to recruit a small number of patients is likely to be easily forgotten unless there is a reasonable financial incentive as such studies rarely provide sufficient intellectual or professional satisfaction.

Financial incentives alone, however, are unlikely to be enough to maintain the necessary interest of the general practitioner to ensure successful

recruitment. We recently managed to enrol 300 patients through 40 general practitioners over five months for a study on seasonal allergic rhinitis. We provided a substantial financial benefit, but the timely completion of the project was also due to intense monitoring. Our clinical research associates visited general practitioners each month and telephoned them each week, generally encouraging them to keep up recruitment, resolving queries, and ensuring efficient provision of drugs, documentation, and investigators' fees.

Generally, it is difficult to get people to do something for nothing, and general practitioners are no exception. Until those organising multicentre clinical trials in general practice and elsewhere learn properly to address the needs of the participants we can expect the failures to continue to outnumber successes.

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- 1 Tognoni G, Alli C, Avanzini F, Bettelli G, Colombo F, Corso R, et al. Randomised clinical trials in general practice: lessons from a failure. *BMJ* 1991;303:969-71. (19 October.)
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Tenure of clinical professorships

SIR,—The idea of giving merit awards for a fixed but renewable term of five years does not seem to have aroused much opposition, and the implications of the change are interesting. On the basis of achievement the larger awards seem likely to be made to younger candidates whereas those who have not fulfilled expectations or, more commonly, have run out of steam will find this reflected in non-renewal or a lower grading. I hope that confidentiality will be scrupulously preserved so that none are humiliated and the public does not draw unjustified conclusions from publication of the awards.

But has the time not come to look at the tenure of professorial chairs in the clinical departments of universities and apply the same considerations? With the introduction in the 1930s and 1940s of full time clinical professorships in the teaching hospitals in place of Buggins's turn came an enormous improvement in the standards of teaching, research, and clinical practice. Very properly, the age at which appointments were made fell substantially so that now the early 40s is probably regarded as the ideal. But what happens when early promise is not fulfilled or the professor runs out of steam? The answer at present is nothing. Yet in some ways the result can be worse than in the 1920s and 1930s. In the days before the NHS, consultants in teaching hospitals retired at 60, though the professorial chair could be held a bit longer. Now the age is 65. Those extra years are useful but rarely very productive, and the deleterious effect of aging are no less in the 1990s than they were 60 years ago.

I suggest that all clinical professorships with charge of departments should have a fixed tenure of 15 years or until the age of 60, whichever comes first, and, at least in the same university, should only exceptionally be renewable. The title, with emeritus added, might normally remain, and the person would go back to clinical practice, personal research, or other activities. Then charge of the department, organising teaching, and fostering research would pass by normal selection procedures to a new person, presumably again in his or her

early 40s, so that medicine would continue to be enriched by a well trained human brain at the peak of its performance. To bring about these changes would entail some self immolating voting by many members of the boards of faculty of medicine in the universities, but perhaps no more than when the full time posts were first introduced all those years ago.

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First among women

SIR,—I despair: yet another article is written about "the world's first woman doctor" being Elizabeth Blackwell—and by someone in Dublin, too.¹

The *BMJ* itself published an article in 1989 on "James" Barry, a woman who disguised herself as a man in order to qualify and practise as a doctor.² Her parentage is uncertain: either her parents were the Buckleys, from Cork, or, I surmise, judging from family and other letters, she was the illegitimate child of James Barry, the Irish artist. She qualified in Edinburgh in 1812 and had an amazing career in the army.

Colours, my stage play about her, was premièred in Dublin about three years ago. I write this letter as I had hoped that fiction might succeed in establishing the truth where history had failed. I have just been commissioned to write a drama-documentary for the BBC radio series *Unsung Heroes*, and I wonder if a wider radio audience might yet help more people to know some of the facts.

I originally thought in a fairly limited feminist fashion that it was a kind of male blindness that obscured the truth—that Dr Barry achieved a position in the army (that of inspector general of hospitals, equivalent to major general) that, I think, has never been equalled since by a woman. She also, incidentally, performed the first successful caesarean section (which both mother and child survived) by an English speaking doctor. But Miles in her book *A Women's History of the World* also seems not to mention Dr Barry.³

Maybe women doctors today find the same difficulties: that what they do, unless they go about disguised as men, somehow does not get recorded or given credit.

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Not Anon

SIR,—The common cormorant or shag
Lays eggs inside a paper bag . . .¹

according not to the versatile poet Anon but to the former medical student Christopher Isherwood.²

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- 2 Isherwood C. The common cormorant. In: Grigson G, ed. *Faber book of nonsense verse*. London: Faber, 1979:292.

Correction

Chorionic villus sampling

A letter by D T Y Liu, published in the journal on 30 November (p 1402), was inadvertently published again on 4 January (p 54).