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Are institutional and individual interpersonal racism the same?

Singh (2007) and Murray & Fearon (2007) surprisingly and erroneously assume that institutional racism and individual interpersonal racism are the same! They dismiss the contribution of institutional racism to systemic problems in the provision of services and service delivery, and argue that problems in the provision of services and service delivery, and argue that a variety of established aetiological factors are more prevalent in some ethnic groups and that this explains high rates of mental illness. This argument is flawed because the vast majority of studies of aetiological risk factors are cross-sectional where an association is usually assumed. Consider the situation of a patient with misdiagnosis of mental illness, who then is unable to find employment (a risk factor) because of their previous (albeit erroneous) diagnosis.

Institutional racism in clinical practice can manifest by lack of opportunities for staff to receive training in cultural competence, culturally inappropriate psychological treatments, inadequate interpretation services, lack of written materials in the patient's language and a range of other issues. This is at great variance with Singh and Murray & Fearson's interpretation that the institutional racism lobby suggests that clinicians in psychiatry are racist. Institutional racism, along with other factors, may also contribute to lower rates of psychiatric admissions for some ethnic groups; for example, Indian and Chinese had lower rates of admission in the 2006 'Count me in' census. Similarly, elderly patients from a range of minority ethnic groups have poor access to psychogeriatric services. Thus, there is a need to critically examine a range of factors, including institutional racism, in generating an explanatory model for both increased and decreased admission rates, and other variables that differ across ethnic groups.

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How nasty has NICE been to people with dementia?

A revised NICE Technology Appraisal restricted the use of acetylcholinesterase inhibitors (AchIs) in Alzheimer's to patients suffering moderately severe dementia based on Mini-Mental State Examination (MMSE) of 20 or below (National Institute for Health and Clinical Excellence, 2006). *R(Eisai Ltd) v NICE* [2007] upheld this guidance, albeit with caveats advising against undue reliance on MMSE scores for those who have learning disability or for whom English is not a first language. In Derby, the new guidance was in place from 1 January 2007 onwards and policed by our pharmacy department where all applications for AchIs must be submitted.

We undertook a mirror image study of my prescribing, comparing data for two 6 month periods before and after implementation (1 Feb 2006 to 31 July 2006 and 1 Feb 2007 to 31 July 2007 respectively).

Eleven patients began AchI therapy in the first period and 22 in the second. In both periods, three of the initiates had dementia with Lewy bodies while the remainder of the patients had Alzheimer's or mixed Alzheimer's vascular dementia. Mean MMSE of the Alzheimer's mixed group was 23.9 (range 14–28) in the first period and 17.7 (range 8–28) in the second ($t=2.79$, $P=0.0098$). In the latter group, six patients were judged to have moderately severe impairment despite MMSE above or below the NICE threshold.

These results suggest that the new guidance has significantly restricted the use of AchIs to those with more severe cognitive impairment but there is little evidence that rate of usage has been curbed. In fact, the publicity surrounding the controversial guidance may have fuelled demand for these agents.

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Reflective practice documentation in portfolio

Seed *et al* (2007) demonstrated that very few psychiatric trainees include evidence of reflective learning in their portfolio. It is worth exploring the reasons behind these results.

As Bouch (2003) highlights, reflecting on our experiences at work is of central importance to learning. Even entry into specialty training programmes require demonstration of capacity for reflective learning (Modernising Medical Careers, 2007). Reflective practice is a key element of continuing professional development (Bouch, 2003) and the new MRCPsych curriculum emphasises reflective practice (Royal College of Psychiatrists, 2007).

Informal discussion with trainees in our trust demonstrated that some of them were not aware of documenting reflective practice in the portfolio, some were concerned about lack of structure for writing in the portfolio and very few complained of lack of time.

Major changes in the training curriculum will probably make the documentation of educational and clinical supervision increasingly important and in the context of the possible introduction of revalidation by the General Medical Council, reflective practice may become an important section of the trainees' portfolio in future.

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