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Enticing GP trainees

Dein *et al*'s article (*Psychiatric Bulletin*, June 2007, **31**, 227–230) is fascinating and worrying, given recent developments in the structure of training rotations. The authors emphasise the importance of exposure to psychiatry after medical school, and that it is too soon to evaluate the impact of the foundation year. Previously, the main opportunity for postgraduate exposure was through GP vocational programmes. In many parts of the country, as a consequence of MMC/MTAS, such programmes have expanded: for example, in the South East, excluding London, the balance between psychiatric and GP trainees has shifted massively in favour of the latter, with over 80 posts being 'converted' this summer. However, simultaneously, 6-month training slots have been reduced now to 4 months' duration, to meet the needs of the GP rotations.

I question whether 4 months' exposure is enough to encourage GP trainees to switch to psychiatry, as has been common in the past. Rather, the structure of the new senior house officer (SHO) jobs, which have moved towards being generic site duty doctors for in-patient units, while the committed psychiatric trainees staff the more interesting community and specialist jobs, is I believe less likely to contribute to the important postgraduate factors of empathy, better working conditions and a sense of fulfilment with improvement or interface with other disciplines.

If we wish to encourage GP trainees to switch to psychiatry, we need urgently to rethink what we provide during their brief 4-month exposure so that it makes a lasting and positive impression, not treat them as workhorses passing briefly through.

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New Ways of Working and the patient

Dr Gee is certainly not the only psychiatrist with misgivings about the New Ways of Working for consultant psychiatrists (*Psychiatric Bulletin*, August 2007, **31**, 315). I share his concerns both in my capacity as a consultant psychiatrist with 20 years' experience and as an NHS patient for the past 4 years. In the unequal relationship of the doctor and patient, an essential element of the healing process is faith in the doctor. The patient wants the doctor to take charge and guide them through the illness. Seeing my consultant physician continuously through thick and thin over 4 years has been extremely helpful. I cannot say the same about my care under other hospital departments where doctors change in a bewildering fragmentation of rotas and sub-specialties.

Psychiatry is now adopting the worst aspects of acute hospital medicine. A patient familiar with a consultant psychiatrist is now handed over to a group of strangers in a crisis team as soon as the going gets tough. Consultant psychiatrists are expected to no longer 'waste' their time seeing patients over extended periods in out-patient clinics. However, I have often been surprised by the gratitude of patients for what seems so little effort, namely simply being there for them. The tradition of doctoring is being abandoned for a role akin to a medicines technician. In this era of user empowerment did anyone ask the patients what they thought about this New Way of Working?

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Improving prescription quality in an in-patient mental health unit

We read with interest the evaluation of prescription quality on an in-patient mental health unit by Ved & Coupe (*Psychiatric Bulletin*, August 2007, **31**, 293–294). We have recently completed an audit of prescription quality of 'as required' medication on our acute psychiatric in-patient ward. All prescription charts (n=90) over a 1-month period were audited, incorporating 282 prescriptions. Similar results were noted to those in the first cycle of the clinical audit by Ved & Coupe (2007). However, we had lower rates of generic prescribing (43 *v.* 96%) and the reason for prescribing 'as required' medications was stated less frequently (17 *v.* 52%). There is a culture of non-generic prescribing in Ireland compared with the UK, most probably fuelled by differing legislation with regard to prescribing liability and dispensing of medications (McGettigan *et al*, 1997). We had higher rates of cancelling medications correctly (78 *v.* 40%).

Unlike Ved & Coupe (2007) we assessed whether nursing staff recorded administering 'as required' medications to patients in the nursing notes after signing for them in the prescription chart and found that they did in 57% of cases. In 90% of these cases an explanation was documented. Nurses were far more likely to record administering psychotropic than non-psychotropic medication (70 *v.* 22%, $P<0.0001$).

Both our study and that of Ved & Coupe (2007) demonstrate that the quality of prescribing can be improved and we agree that continuous quality assurance requires ongoing data collection, review of those data and action. The greatest deficits in prescription quality in our acute in-patient unit were in prescribing medications generically and stating a reason for prescribing 'as required' medication.

McGETTIGAN, P., McMANUS, J., O'SHEA, B., *et al* (1997) Low rate of generic prescribing in the Republic of Ireland compared to England and Northern Ireland: prescribers' concerns. *Irish Medical Journal*, **90**, 146–147.

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OSCE: experience as a simulated candidate

Philip Seager's letter (*Psychiatric Bulletin*, August 2007, **31**, 316) about performing

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as a simulated patient reminded me of a recent experience as a simulated candidate in the Royal College of Psychiatrists' pilot objective structured clinical examination (OSCE).

Significant changes to the College Membership examinations are imminent. One of these is the introduction of an OSCE in Spring 2008 as the sole clinical component. This inevitably required training for consultants in both the theory and practice of examining an OSCE. Specialist registrars were invited to attend as mock candidates and I arrived to find I was the only one who had done so. Luckily several of the consultants also agreed to act as candidates.

I have experienced OSCEs at first hand, both at medical school and as part of the MRCPsych part I examinations. I am familiar with the structure and have fine-tuned my style in the hope of improving my performance. This was not the case for many of the consultants present at the pilot.

We rotated through six linked stations, involving assessment of self-harm, schizophrenia, depression following a myocardial infarct and dementia with paranoid delusions, and preparing a court report. I was surprised by the level of anxiety I experienced but felt able to cope with this and was pleased to hear that I performed at a standard sufficient to 'pass'. What was interesting was that some of the consultants struggled to reach this standard, despite having much more clinical experience, but without any personal OSCE experience. Therefore, I feel that future candidates need to consider several factors when seeking examination practice, not least the training and actual experiences of senior clinicians.

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Specialist beds for learning disability

Lyall & Kelly (*Psychiatric Bulletin*, August 2007, **31**, 297–300) looked at patterns of admission for people with learning disability to specialist psychiatric beds and highlighted the lack of community resources as a cause of delayed discharge. We performed a survey of patterns of admission and characteristics of patients admitted to a 12-bedded specialist learning disability unit. This unit serves a population of 380 000. Thirty-six people were admitted over a period of 2 years and accounted for 42 admissions; 25 patients (69%) had mild, 5 (14%) moderate and 6 (17%) severe learning disability. Sixteen (38%) admissions were regarded as having delayed discharges. The mean duration of admission was 210 days but when the duration of delayed discharge was excluded this dropped to 103 days. Our experience suggests that a lack of community resources leading to delayed discharges might be more widespread.

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Safe from harm: the senior house officer experience

Staff safety continues to be of concern in psychiatric practice. This is reflected in studies of the incidence of violence on in-patient wards (Chaplin *et al*, 2006) and recent recommendations from the College (Royal College of Psychiatrists, 2006). A recent study of levels of abuse experienced by specialist registrars in Northumberland (Reddy & Kaplan, 2006) both dovetailed and contrasted with our study of violence experienced by senior house officers (SHOs).

We carried out a questionnaire survey of all SHOs on the South East Scotland training scheme in 2004 (n=74) and repeated it in 2007 (n=52) to ascertain the stability of our findings. A good response rate of 76% was achieved on both occasions.

In 2004, 35.7% had experienced at least one physical assault but only 40% of these had reported it. Almost all the trainees had felt at risk of violence at some time (92%). Training in the management of aggression had been attended by 84%. The findings in 2007 were broadly similar, with 35% experiencing physical assault, 50% reporting it, and again the majority feeling at risk (87%). Training had been attended by 72.5%.

These results contrast with those of Reddy & Kaplan for specialist registrars, of whom few (23%) had had training but only 9% had experienced physical abuse. In our area it is the SHOs who are generally first on call for emergency assessments. We conclude that training in the management of aggression is of itself insufficient protection against assault for this relatively junior group of psychiatrists.

CHAPLIN, R., McGEORGE, M. & LELLIOTT, P. (2006) The National Audit of Violence: in-patient care for adults of working age. *Psychiatric Bulletin*, **30**, 444–446.

REDDY, S. & KAPLAN, C. (2006) Abuse in the workplace: experience of specialist registrars. *Psychiatric Bulletin*, **30**, 379–381.

ROYAL COLLEGE OF PSYCHIATRISTS (2006) *Safety for Psychiatrists* (Council Report CR134). Royal College of Psychiatrists.

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Assessment of mental capacity

We read with interest the article by Church & Watts on the assessment of mental capacity (*Psychiatric Bulletin*, August 2007, **31**, 304–307). The Mental Capacity Act 2005 came into effect in April 2007. However, are clinicians and other health professionals prepared and equipped to implement the Act? Any attempt to clarify capacity assessment as in the flow chart described by Church & Watts is helpful. In a survey earlier this year we found that many medical professionals outside the field of mental health are unaware of the Act and have had no training in assessing mental capacity. This is highly relevant as the Act states that 'the person who is required to assess an individual's capacity will be the person contemplating making a decision on behalf of the person who is to be assessed'. Most old age psychiatrists are familiar with requests from general wards to assess 'this patient's capacity', especially when a discharge placement is in question. The Act is clear that having a psychiatric diagnosis (e.g. dementia) does not imply lack of capacity as long as the person passes the components of the capacity test. However, the Code of Practice also lists instances when an 'opinion from a professional may be required'. In the coming months will non-psychiatric clinicians stop sending their referrals or will liaison and old age psychiatrists be flooded with requests for assessment? What is now required is clear guidance drawn up jointly by primary care, acute and mental health trusts, and training to be widely available to all professionals.

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