intervention for psychosis services, exercise programmes', and also stated 'We are aware of some excellent serviceswhere anyone would be confident to recommend a friend or family member be treated'. I have seen several media depictions of the report, including in the *Guardian*, BBC News website and the *Independent*; they were all strongly pessimistic as regards the healthcare system and condemning of the treatment of schizophrenia.

I appreciate that there are shortcomings and areas that need to be highlighted. As mentioned, the report has achieved this in some areas, to some extent. However, many of the deficits promulgated are insolvable without extra resources; focusing on them without offering resources or solutions creates unrealistic and unattainable expectations and sets services up to fail. Additionally, the report propagates many shortcomings (especially as regards patient involvement and community services) without confronting the uncomfortable truth: that many patients with schizophrenia, especially if actively psychotic, or without insight, motivation or capacity, need high levels of care and guidance, and yes, sometimes it is against their will. Without clearly explaining these factors to the cynical general public, and the sensationalist media, there is a danger that frustrations and disappointments towards the illness might be projected on (and thereby disempowering) those that try their best to treat it, under unfavourable conditions and inviolable boundaries.

The report demurs at the stigma of schizophrenia and encourages battle against it, and rightly so. But what does it do for the stigma of psychiatrists?

1 Schizophrenia Commission. *The Abandoned Illness: A Report by the Schizophrenia Commission*. Rethink Mental Illness, 2012.

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Can old age psychiatry attract trainees to psychiatry?

As an old age psychiatrist with a liaison commitment, I agree with Solomon & Ranjith.[1] If the Royal College of Psychiatrists and training programme directors want to address the recruitment issue that troubles psychiatry, we need to be more proactive about how we attract people into the specialty.

For many years, general adult psychiatry has been the focus of government and health board investment which resulted in super-specialisation. Old age, on the other hand, has not had this prioritisation, with the result that we have remained generalists, with multifaceted skills. For this very reason old age psychiatry is appealing: by keeping control of our service, we keep our autonomy and thus our job satisfaction. Retaining a mode of working which provides a varied working week appeals to would-be general practitioners (GPs), who appreciate the continuity provided by community working with the luxury of getting to know their patients.

Working with older people requires the use of to-date medical knowledge on a daily basis, particularly general medicine and neurology. Old age liaison in particular requires medical knowledge gained at university and in postgraduate jobs. Being based in general hospital it demands not only the synthesis of medical and psychiatric knowledge, but the ability to communicate at many levels, thus making it particularly appealing to those potential psychiatrists for whom being a 'real doctor' is important.

The problems encountered by Dr Dudleston[2] are symptomatic of New Ways of Working gone awry. It is concerning that a scheme conceived by the College and the Department of Health as a way of reducing workplace stress for psychiatrists has been misinterpreted and misapplied by managers, resulting in disempowerment of the role of the consultant psychiatrist, as well as huge regional variation in how services are provided and how training occurs, both at undergraduate and postgraduate levels.[3–5]

Old age psychiatry is the perfect vehicle for multi-disciplinary working. I could not do my job without the support of my community mental health team, a group of autonomous individuals whose skills allow me as the medic in the team to focus on the more complex and medical needs of our patients, whether as in-patients, out-patients or in liaison service. This symbiotic relationship has not evolved from New Ways of Working; rather, it has come about from a realisation that the skills of the medic in the team are better used for diagnosis, treatment, clinical decision-making, risk management and service development.

There is something to be said for drawing people into the specialty with the familiar and comfortable. Once secure in their choice, they can explore the diverse and fascinating subspecialties that psychiatry can offer. It is easier to defend a choice when you know that at many levels psychiatry is not that much different to other branches of medicine. We have something to learn from our colleagues in palliative care and oncology who do not doubt the worth of the jobs they do because of lack of a 'cure', and neither should we.

Below are the views of two psychiatric trainees who started out with very different career paths.

From academic pathology to old age psychiatry – I note with interest the recent discussion regarding the decline in the number of psychiatric trainee applicants. As someone who was until shortly before application time 'sold' on another specialty, I feel a personal perspective on why I changed my mind may be of interest. Following an intercalated degree in anatomy and an honours paper discussing histopathological techniques, I was sure I was destined for a career in pathology. I pursued several modules in pathology, a taster week and a placement in my FY2 year. I also undertook a placement in psychiatry (old age) in FY2, which proved to be a turning point. As I was doing an academic foundation programme, I was of course interested in what fields of research were being pursued at that time. Although more is being revealed about organic causes of psychiatric conditions as the research methods become more sophisticated, there remains much to be discovered. This makes it a very exciting time to be part of psychiatry. Working in an old age psychiatry placement highlighted both the organic component of psychiatric conditions and the requirement for research into these, in particular conditions pertinent to an aging population. This placement also changed my mind regarding old age psychiatry as it came across as a more medical specialty owing to patients having a number of comorbidities which require medical treatment, or indeed having an acute confusional state that is the result of a medical insult. Foundation year placements may aid to show that

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the boundaries between the 'Cinderella specialty' and general medical complaints are more blurred than initially anticipated. Scotland has the PsyStar Academic specialist registrar programme, but currently there is no core training academic programme. Such a programme may encourage the academically minded to do a training programme in psychiatry.

From general practice to psychiatry – I entered psychiatry core training in 2012, having qualified as a GP in 2010 and worked in general practice for 2 years. Why the change? It is not that I dislike general practice. Yet psychiatry offers so many good prospects, areas that are challenging and fulfilling. I like that psychiatry is holistic, dealing with the whole person, not just the bit of the body that is hurting or diseased. The context – family, work, events in the past and present – in which the person finds him or herself cannot be ignored. Moreover, in psychiatry there is time to explore these issues. In psychiatry there is an emphasis on the multidisciplinary team. Everyone has a part to play – the specific skills of each person are valued. It is a privilege to work alongside these dedicated professionals. Like GPs, psychiatrists look after their patients over long periods of time. Continuity of care is important, and I found that a good reason to consider psychiatry. I was also attracted by the intellectual challenges. Good psychiatrists make it look easy, but there is a depth of knowledge and understanding required, spanning the fields of neurology, psychology, pharmacology and more! Ultimately, though, the reason for changing to psychiatry was that I like it. I like the patients, everyone a unique human being with his or her own story. I get up in the morning and look forward to going to work. So far, I have had no regrets about the change. It is early days to know which field I would prefer, but I am attracted to old age psychiatry. My encounters with older folk and their families have been among the most thought-provoking and rewarding I have faced in medicine. Add to that the real prospect of further advances, particularly in the treatment of dementia, and old age psychiatry presents itself as an excellent career choice.

1 Solomons L, Ranjith G. Are some subspecialties better with foundation doctors? *Psychiatrist* 2012; **36**: 35–6.

2 Dudleston KE. Recruitment in psychiatry. *Psychiatrist* 2012; **36**: 196.

3 Fearnley ER. The psychiatry experience from a medical student perspective. *Psychiatrist* 2012; **36**: 272.

4 Mozdiak REC. The experience of a medical student who was 'converted' to psychiatry (e-letter). *Psychiatrist* 2012; 7 August.

5 Sinclair HR, Patterson JR. Re: Thoughts for the future, the psychiatry experience from a medical student perspective (e-letter). *Psychiatrist* 2012; 16 July.

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Red light – don't drive!

As it happens, we have been grappling with the same issues as Curwen & Jebreel,[1] namely low rates of documented action taken in relation to driving risk in our crisis resolution team. We would like to share the approach we arrived at, which might inspire others.

As was indeed suggested by Curwen & Jebreel, we did place a poster regarding the guidelines for driving with psychiatric illness in our team's work space, and repeatedly discussed the issue at team meetings. Unfortunately, this did not make much difference and documented action remained near zero. More successful was indicating driving status as part of the patient's details on our overview boards and including a simple screening tool in the admission pack. This pack is used by practitioners at first assessment and the tool simply looks at the three general domains of psychiatric illness covered in the guidelines: (1) depression, anxiety; (2) psychosis, hypomania, mania; (3) dementia. The rater needs to broadly rate each of these domains, assigning each a colour: green – low risk and no action needed, amber – sufficient risks present to refer for a medical opinion, red – risks are overwhelmingly clear and driving needs to stop immediately.

In the case that driving needs to stop, a letter is available in the admission pack, written on behalf of the unit, explaining the need to do so.

1 Curwen J, Jebreel A. Advice on driving while under the care of a crisis resolution team: findings from two audits. *Psychiatrist* 2012; **36**: 424–6.

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