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Greetings survey

There has been little research into psychiatric patients' preferences in beginning their interaction with a psychiatrist. In general, doctors and medical students are encouraged to shake hands with the patient, address them by name and introduce themselves. A survey on patient expectations for greetings has been reported by Makoul *et al*.[1] We present here a similar survey involving psychiatric out-patients.

We invited individuals attending out-patient appointments in adult and old age clinics to fill in a tick-box questionnaire comprising four questions about specific greeting behaviours.

1. Would you prefer to be addressed by your first name, last name or it does not matter?
2. Would you prefer the doctor to shake your hand or not?
3. Should doctors introduce themselves using their first name, last name, both names, and/or as a doctor?
4. Would you want the doctor to explain their role in your healthcare?

All responses were analysed for content.

Overall, 98 responses were obtained at the end of a month, 70 from the under-65 age group (range 19–64 years old, mean age 44.3 years) and 28 from the over-65 group (range 65–94 years old, mean age 76 years); 50% of responders under 65-years-old and 64% of over 65-years-old were female.

On the question of how the person prefers to be addressed, 91% wanted their first name to be used when greeted, the figures being similar for older and younger patients; 20 did not comment. With regard to shaking hands, 86% wanted the physician to shake their hand during the greeting, with a stronger preference among older people; 44 did not comment. Further, the majority (68%) preferred the doctor to introduce themselves as a doctor and with their first and last name; 21 did not comment. Almost all respondents (98%) wanted an explanation of the doctor's role in healthcare; 17 did not comment.

The figures in our study are similar to those found by Makoul *et al*[1] and show that psychiatric out-patients wish to be treated similarly to those attending any other general medical clinic. However, the stigma and potential dangerousness of encounters with psychiatric patients may prevent doctors from treating them so and needs to be addressed in training.

Psychiatric interviews involve a potentially intense emotional experience. With respect to shaking hands, the importance of being sensitive to non-verbal cues is paramount. At least at first contact, we must use patients' first and last names to assure identification and perhaps subsequently ask about patients' preferred from of address. A comfortable form of introduction for doctors would be to introduce themselves fully at least the first time. Explaining our role is an essential component of introduction, and avoids patient confusion and anxiety at the outset. All of the above may vary depending on culture and ethnicity, and perhaps the different circumstances when we interview patients. However, greetings constitute an important part of establishing the therapeutic relationship with patients and as such need appropriate attention.

1 Makoul G, Zick A, Green M. An evidence-based perspective on greetings in medical encounters. *Arch Intern Med* 2007; **167**: 1172–6.

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Antipsychotic prescription trends according to ethnicity

The UK is ethnically very diverse.[1] It has been shown that individuals from Black and minority ethnic groups have poorer self-reported experiences of pathways in mental health and worse outcomes.[2] The National Institute for Health and Clinical Excellence (NICE) guidelines for anti-psychotics state that individuals on conventional antipsychotics who do not tolerate the side-effects or whose symptoms are not controlled should be switched to atypical agents.[3] The Department of Health recommendations state that prescribing for Black and minority ethnic patients should be audited on a yearly basis to ensure that prescribing discrepancies between ethnicities continue to fall.[4]

Bolton, in Greater Manchester, has a total population of 261 037, of which Asians represent the largest ethnic minority (8.5%).[1] We examined whether there was significant difference in the proportion of Asian patients switched from typical to atypical antipsychotics compared with White patients. We also looked at the reasons for these switches and at adherence to NICE guidelines.

A total of 178 patients were studied through retrospective case-note analysis. All Asian patients with a diagnosis of psychotic disorder were selected from the open referral list in a Bolton mental health unit. To ensure they were initially on a conventional antipsychotic, we selected patients that had onset of illness prior to the advent of clozapine (the first atypical antipsychotic) in 1990. Overall, 36 Asian patients were eligible for inclusion in the study and a total of 72 similar White patients were then randomly selected for comparison.

There was no significant difference in the proportion of Asian patients switched to atypical antipsychotics (where indicated) compared with the proportion of White patients ($P = 0.489$, 95% CI −0.042 to 0.42). Most switches in medication were made due to poor tolerability than ineffectiveness, but this was not significantly different between the two groups ($P = 0.577$, 95% CI −0.056 to 0.491). Documentation of tolerability was 100% for the Asian group and 97% for the White group; documentation of effectiveness of antipsychotic treatment was 100% for both groups.

There is indication of equity in prescribing and adherence to NICE guidelines for both Asian and White patients in Bolton, Greater Manchester. This is encouraging given the difficulty that Black and minority ethnic groups experience with outcomes in healthcare. However, this particular study would need replication on a larger scale to establish national

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trends. Furthermore, such information would help contribute to relevant research in mental health service provision to Black and minority ethnic groups in the UK.

1 Office for National Statistics. *2001 Census*. ONS, 2001.

2 Wright S, Bindman J, Thornicroft G, Butcher M. *Thematic Review of NHS Funded Mental Health Research in Relation to the National Service Framework for Mental Health*. Institute of Psychiatry, 2000.

3 National Institute for Health and Clinical Excellence. *Schizophrenia – Atypical Antipsychotics* (TA043). NICE, 2002.

4 Sashidharan SP. *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*. Department of Health, 2003.

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Educational factors associated with e-learning

In her excellent editorial, Elizabeth E. Hare discusses e-learning for psychiatrists.[1] We wish to highlight another e-learning resource for psychiatrists, of which the readership may not be aware.

Mayes *et al* suggest that 'there are really no models of e-learning *per se* – only e-enhancements of models of learning'.[2] So as with all learning, e-learning needs to be based on good pedagogical principles, with good instructional design as a foundation.

Further, Hattie conducted a meta-analysis where he examined the relative effectiveness of various educational factors on student achievement.[3] The top seven in terms of effect size were: reinforcement (1.13), student's prior cognitive ability (1.00), instructional quality (1.04), direct instruction (0.82), remediation/feedback (0.65), student's disposition to learn (0.61) and class environment (0.56).

It is possible to see how e-learning may enhance 'reinforcement' and 'student's disposition to learn'. Video e-learning represents another form of e-learning, which also addresses the 'direct instruction' and 'class environment' interventions – it may be easier to learn from a 'live' teacher talking with credibility and passion directly to the student in a classroom, rather than reading the same words from written text. By way of example, the *Video Journal of Psychiatry* is a sponsored online service providing classroom-like lectures on MRCPsych curricula and continuing professional development topics to Irish psychiatrists (www.vjpsych.ie).

Cook *et al* have shown that internet-based learning is beneficial to students and is probably as effective as the traditional instructional methods.[4] What is needed now is more research, comparing the efficacy of the various internet-based interventions.

1 Hare EE. E-learning for psychiatrists. *Psychiatr Bull* 2009; **33**: 81–3.

2 MayesT, de Freitas S. JISC e-Learning Models desk study Stage 2: Review of e-learning theories, frameworks and models. Joint Information Systems Committee, 2004.

3 Hattie J. *Influences on Student Learning* (inaugural lecture). University of Auckland, 1999 (http://www.education.auckland.ac.nz/webdav/site/education/shared/hattie/docs/influences-on-student-learning.pdf).

4 Cook DA, Levinson AJ, Garside S, Dupras DM, Erwin PJ, Montori VM. Internet-based learning in the health professions: a meta-analysis. *JAMA* 2008; **300**: 1181–96.

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General practitioners and early intervention in psychosis

Delay in the initiation of treatment in individuals with first-episode psychosis has been associated with poorer long-term outcomes.[1] El-Adl *et al* report on general practitioner (GP) experiences of patients with a first psychotic episode.[2] However, I have a number of concerns about the reported results.

The low reported incidence of new cases per year within the authors' locality ($n = 100$) was demonstrated by the majority (68%) of GPs seeing only one or two such individuals per year. I find it difficult to see, given these low cell counts, how GPs could answer questions about initiating treatment (10%, 25%, 50% and 75% of the time) and thus conclude that GPs are unlikely to start treatment before referring to secondary care services.

The information requested from the GPs regarding engagement of patients with first-episode psychosis and causes of delayed referral are based on these low patient numbers and would be subject to recall bias on behalf of the GP. Getting the patients' views on barriers to mental health services would certainly have helped triangulate the data.

I was also concerned that the data published were 5 years old and as such the current generalisability of these results could be questioned.

With the National Institute for Health and Clinical Excellence schizophrenia guidelines recently updated[3] and early intervention/crisis resolution teams the norm rather than exception, El-Adl *et al* echo the view that active engagement with our primary care colleagues is paramount in ensuring these patients receive both a responsive and effective service.

1 BarnesTRE, Leeson VC, Mutsatsa SH, Watt HC, Hutton SB, Joyce EM. Duration of untreated psychosis and social function: 1-year follow-up study of first-episode schizophrenia. *Br J Psychiatry* 2008; **193**: 203–9.

2 El-Adl M, Burke J, Little K. First-episode psychosis: primary care experience and implications for service development. *Psychiatr Bull* 2009; **33**: 165–8.

3 National Institute for Health and Clinical Excellence. *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Adults in Primary and Secondary Care (update), CG82*. NICE, 2009.

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General practitioners and early intervention in psychosis: reply

We wish to express our thanks to Dr Bowers for the interest in our article.[1] Dr Bowers feels that the majority of GPs reporting seeing only one or two patients with first-episode psychosis a year is a low figure. However, this agreed with Shiers & Lister's findings.[2]

Dr Bowers expressed reservations about the GPs' ability to answer questions about their prescribing trends to patients with first-episode psychosis. I may disagree with this view as the low number of patients does not exclude or make it difficult for GPs to comment on engagement or otherwise. It is our view that clinicians, including GPs, may be more able to remember cases that are not very frequently seen than common ones.

Dr Bowers' suggestion that getting the patients' views on barriers to mental health services would certainly have helped to triangulate the data – this puts forward the idea for another study. The scope of this study was about GPs' experience and not patients' or carers' experience.