



the columns

correspondence

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