

In 2009, we completed an audit with colleagues at North Derbyshire Mental Health Services NHS Trust. The results illustrated that physical examination on admission to an in-patient unit increased from 67 to 83% by the end of the audit cycle. The reasons for not examining patients varied from 'transferred from medical ward' to 'team to review tomorrow'. We encouraged the consultant-led teams to take more responsibility in ensuring that a complete physical examination (including investigations such as baseline bloods and electrocardiograms) is done for every patient admitted to the unit, and also recommended quick and easy access to physical health equipment, especially out of hours.

While I appreciate the emphasis of the Royal College of Psychiatrists on increasing the awareness of physical illnesses in our client group and the importance of their detection, I believe actions speak louder than words. Our under-performance in this area is due to problems at multiple levels. Training in psychiatry has become completely detached from medicine. We need to increase psychiatric trainees' exposure to medicine by incorporating physical examination in the MRCPsych curriculum nationally and possibly offering a compulsory rotation in medicine during core training. We also need to change the ethos within psychiatric teams (in-patient and community based) by encouraging psychiatric nurses to also improve their medical skills.

It can be quite tricky in out-patients to address physical health problems while also managing mental health issues. Like other services, why can't we have a dedicated nurse at the out-patient clinic who records blood pressure, measures height, weight, hip and waist circumference, and does all the routine blood tests for every patient, before they go in to see the doctor?

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Yasir Abbasi, ST5, North Trent Psychiatric Rotation, Crisis Resolution and Home Treatment, Bassetlaw Hospital, Worksop, UK, email: dryiabasi@yahoo.com

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Attitudes to ECT – a nebulous concept with important implications

Kinnair *et al*¹ raise some important points regarding training and teaching students on electroconvulsive therapy (ECT). Some of the questions used, particularly in assessing students' attitudes to ECT, have been used in similar studies^{2,3} and would therefore carry some face validity. Clearly, it is important to consider the sequence of teaching events in any instructional design of a teaching block; however, I would disagree with some of the authors' conclusions. With such a descriptive study design, the use of binary variables (yes/no answers) and the absence of *P*-values, one cannot infer any significant differences between Groups A, B, C and D with regard to changes in knowledge of ECT. The relatively smaller sample sizes of these groups compared with the baseline

sample would make a Type I error more likely, that is any differences seen could be due to chance.

Intuitively, one would expect either Group B or C to do better with their follow-up knowledge questions, simply based on constructivist theory (i.e. building on previously attained knowledge). In Group B, a certain amount of knowledge will be acquired from simply watching an ECT procedure. The authors did not state how soon after the lecture and/or witnessed ECT event, students were asked to complete the questionnaire. One cannot therefore assume a limited benefit (in terms of knowledge obtained) from watching ECT before receiving a lecture, as this could equally be due to having the lecture closer to the questionnaire.

I find the absence of any tables to explain the results of their attitudes questions somewhat disappointing. Previous research in this area has shown that medical students' attitudes to ECT can be improved by receiving a didactic lecture on ECT,⁴ as well as observing an ECT application (either live or a pre-recorded video),⁵ so it is not surprising that Group B showed improved attitudes on two of the questions compared with Group D. It would have been interesting to know how many of those students who had seen either *One Flew over the Cuckoo's Nest* or *Beautiful Mind* belonged to Groups A or D, which could explain the different response with regard to question 10 – 'I would agree to have ECT if I was depressed'.

Better knowledge of ECT, particularly self-perceived knowledge, does not necessarily imply better attitudes to ECT.⁶ If we want to attract more students to our profession, further research in this area is essential to help unveil some of the secrets behind students' negative perceptions, attitudes and prejudices with regard to ECT.

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Schalk W. du Toit, Specialty Registrar, ST6 General Adult Psychiatry, NHS Grampian, Royal Cornhill Hospital, Aberdeen, UK, email: s_dutoit@doctors.org.uk

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Concerns over professional boundaries remain unresolved

The Executive Committee of the Spirituality and Psychiatry Special Interest Group (SPSIG) of the Royal College of Psychiatrists has made a rather late response¹ to Harold Koenig's editorial² published in this journal in 2008. We were co-signatories to a letter³ that was highly critical of some of

Koenig's proposals. These were that a spiritual history should be taken from all patients, even where the patient is resistant to this; that patients' healthy spiritual or religious beliefs should be supported and unhealthy beliefs should be challenged; and that under some circumstances it is appropriate to pray with patients. Although we fully accept that it is sometimes appropriate to explore spiritual or religious issues with patients, we remain seriously concerned that these more controversial practices breach fundamental professional boundaries. Furthermore, the College appears to be lending tacit support for them.⁴

Although our letter³ has been referenced in a number of publications by members of the SPSIG Executive Committee (e.g. their recent book),⁵ our concerns over boundary violations remain unanswered. Indeed, Larry Culliford⁶ has rather exacerbated our concerns by suggesting that boundary breaches might a good thing; that this might have spiritual benefits for clinicians; and that boundaries are in any case illusory.

The General Medical Council position on these matters is clear. Their supplementary guidance on personal beliefs⁷ states:

You should not normally discuss your personal beliefs with patients unless those beliefs are directly relevant to the patient's care. You must not impose your beliefs on patients, or cause distress by the inappropriate or insensitive expression of religious, political or other beliefs or views. Equally, you must not put pressure on patients to discuss or justify their beliefs (or the absence of them).

In our opinion, it is obvious that Koenig's contentious recommendations are not compatible with this guidance. Although Dein *et al*¹ acknowledge the risk of boundary breaches, and advocate extreme caution in praying with patients, they do not reject the practice. Indeed, it is implicitly left to the individual clinician to decide whether to pray or not.

We can think of no example of a permissible practice in one-to-one clinical interviewing that is acknowledged to be hazardous to patients to this extent. We cannot understand why SPSIG does not simply state that prayer with patients in clinical settings is unacceptable. We feel that it would be helpful if they explained.

Declaration of interest

The authors have a range of personal convictions, including atheist, Buddhist, Methodist, Roman Catholic and non-denominational faith.

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Rob Poole, Professor of Mental Health, Glyndwr University, Wrexham Academic Unit, Technology Park, Croesnewydd Rd, Wrexham, LL13 7YP, email rob.poole@wales.nhs.uk; **Robert Higgs**, Consultant General Adult Psychiatrist, Merseycare NHS Trust, Liverpool; **Gill Strong**, Community Mental Health Team Manager, **Gordon Kennedy**, Community Mental Health Team Manager, **Sue Ruben**, Consultant General Adult Psychiatrist, Betsi Cadwaladr University NHS Trust, North Wales; **Richard Barnes**, Old Age Psychiatrist, Merseycare NHS Trust, Liverpool; **Peter Lepping**, Visiting Professor, Glyndwr University, Wrexham; **Paul Mitchell**, Psychotherapist, Merseycare NHS Trust, Liverpool, UK.

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Correction

Controlled comparison of two crisis resolution and home treatment teams. *Psychiatrist* 2010; **34**: 50–4. The title of this paper should read: A controlled comparison of the introduction of a crisis resolution and home treatment team.

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