Modernising medical careers

Dr Herzberg and colleagues (Psychiatric Bulletin, July 2004, 28, 233–234) describe the forthcoming Foundation Programme changes as a ‘win–win’ position for psychiatry. My own view is a great deal more pessimistic.

It is certainly the case that, at an early stage in their postgraduate careers, more young doctors will be getting an exposure to psychiatry (usually of four months’ duration), and this may well increase the numbers of keen and appropriate applicants for specialist senior house officer (SHO) posts in psychiatry. However, in Scotland, it seems clear that Foundation Year 2 placements in psychiatry will be generated by sacrificing those same specialist SHO posts. Locally, for example, we are likely to reduce from 21 to 16 career SHOs on the Aberdeen training scheme. The changes give rise to no additional funding and, unlike in the English Deaneries, there are no plans here to create extra SHO posts.

While increasing excellence and numbers of applicants for specialist SHO posts will help, it is not the major issue with regard to the depleted consultant workforce. As the College’s recent survey (Mears et al, 2002) demonstrated, of 100 trainees who actually get as far as sitting Part 1 MRCPsych, only about 40 will end up as consultant psychiatrists. Essentially, there are too few SHOs becoming specialist registrar posts. Locally, we have a shortage of applicants for specialist registrar posts, but have more than adequate numbers of good applicants for SHO posts. The Foundation Programme can only exacerbate this imbalance through reducing specialist SHO numbers.

There is another additional consideration for the shortage ‘sub-specialty’ of general adult psychiatry. It is likely that Foundation Year 2 training placements will be predominantly in psychiatry, displacing current career SHOs. These rapidly rotating, inexperienced trainees will place further strain on the service and upon already stressed consultants, potentially making the specialty even less attractive to potential specialist registrars, lowering consultants’ retirement ages further, and generally compounding our recruitment and retention problems.

I would regard the views expressed by Dr Herzberg and colleagues to constitute complacent optimism. I really do hope that such views about the Foundation Programme changes are not mirrored in the College and that all possible steps will be taken to attempt to prevent reductions in specialist SHO training posts.


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Research activity of specialist registrars in psychiatry

Petrie et al (Psychiatric Bulletin, 2004, 27, 180–182) identify many of the negative aspects of conducting research as a trainee. However, an opportunity has been missed to examine the type of research being conducted and trainees’ opinions on the positive aspects of doing research. In our opinion, research taught us more about juggling competing demands, negotiating skills, ethical dilemmas and organisational competence than any other experience as a psychiatric trainee. If research sessions were used for another purpose (as more than half the responders wished) this valuable training opportunity would be lost. A consultant needs much more than just clinical skills.

Further, using successful publication as an outcome measure of research sessions ignores the many other benefits research can provide. To those benefits noted above should be added the understanding of the process of project development, increased knowledge in the area of study, an appreciation of the demands of academic and clinical roles and transferable skills such as information technology, writing skills and independent working (Hull & Guthrie, 2000). We had both finished our training before definitive publications in major journals were published, but neither felt our time had been wasted.

Interesting findings in this survey include the relatively small numbers of trainees who had difficulties recruiting subjects (10, 31%) and funding (4, 12%).

Staff attitudes to smoking in an Irish mental health service

Stubbs et al (Psychiatric Bulletin, June 2004, 28, 204–207) found that the majority of mental health staff in an inpatient setting did not favour a total ban on smoking. In the context of the ban on smoking in enclosed workplaces introduced in the Republic of Ireland in March 2004 (Public Health (Tobacco) (Amendment) Act 2004), the smoking policy committee of our mental health service in the Northwest of Ireland conducted a survey seeking the views of, among others, staff (n=174, 28% smokers) prior to its introduction. The legislation exempts patients (but not staff or visitors) in psychiatric hospitals. Of the respondents, 89% were in favour of the ban being implemented throughout our mental health service despite 78% believing that this would prove difficult or very difficult. Support for the ban among smokers was less (77%), although still quite high.

The Irish legislation has provoked much debate in Ireland and elsewhere since its introduction and public support has been remarkably high with 82% of Irish people still in favour five months after its implementation (Irish Department of Health, http://www.dh.gov.uk/assetRoot/04/08/66/57/04086657.pdf August 2004). Our findings appear to reflect the overall attitude of the Irish people toward the smoking ban in public places rather than those of the mental health staff surveyed by Stubbs et al. As this important public health debate develops in the UK, it is incumbent upon mental health professionals to add their voice, particularly in relation to the issue of whether to exempt mental health facilities from any proposed smoking legislation.

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Column(s) Correspondence
As both issues tend to be problematic for even the most experienced and battle-hardened researcher is this a reflection of the sort of studies being conducted? Of course, to participate in larger studies would include the attendant risk of delayed or indeed no publication!

Declaration of interest

A.M.H. and M.G. both undertook full-time research placements as higher trainees.

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Mental health review tribunals and legal representation – equality of arms?

Due to the influence of the European Convention on Human Rights and Fundamental Freedoms and the enactment of the Human Rights Act 1998, quite properly, virtually all patients are legally represented in Mental Health Review Tribunals. Indeed, the European Court of Human Rights has decided that in certain circumstances patients’ rights may be breached if they are not represented in proceedings, even when, in fact, they have not requested a lawyer (Megyeri v. Germany, 1992). However, it is important to note that both sides of tribunal proceedings are not treated equally.

One of the basic tenets of justice is the concept of equality of arms, i.e. ‘a reasonable opportunity of presenting the case to the court under conditions which do not place him in substantial disadvantages vis-à-vis his opponent’ (Kaufman v. Belgium, 1986). The expression of this in regard to tribunal proceedings is not lawful. It could this in itself be seen as discriminatory and thus, in itself, contrary to the Human Rights Act? Lack of resources are often cited as the reason for the Trust not to be legally represented but should certainly not be at issue here and the courts have already declared, in relation to tribunal delays, that the state has an obligation to fund important human rights issues irrespective of cost (R. v. MHRT and Secretary of State for Health, ex parte KB and others (2003)).

I suggest that this fundamental imbalance has been overlooked as an issue for far too long and is worthy of further debate and, hopefully, rectification.

Declaration of interest

I am a medical member of the Mental Health Review Tribunal.

R. on the application of Mersey Care Trust v. MHRT (2003) EWHC1 182 (Admin).
R. v. MHRT and Secretary of State for Health, ex parte KB and Others (2003) EWHC193 (Admin).

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Copyings letters to patients

Sarah Hulin-Dickens (Psychiatric Bulletin (Correspondence) August 2004, 28, 305) expresses considerable concern about the issue of copying letters to patients. In contrast, my experience over 15 years of this practice is very positive. Parents are extraordinarily grateful and the patients themselves have no hesitation in correcting any errors and pointing out any omissions. The letters form a useful forum for further discussion, as well as a reminder of previous discussions. On no occasion have I ever received a complaint, either from a patient, a parent or any of the many professionals who receive copies of such letters.

This experience is shared by a number of colleagues and I hope that Dr Hulin-Dickens will feel reassured.

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Pharmacogenetics and addiction services

I support the view of Hodgson et al (Psychiatric Bulletin, August 2004, 28,
298–300) that future developments in genetics may lead to tailored treatments for psychiatric patients. Currently in addiction services, these technologies are not yet generally in use. However, recent developments suggest they may soon be available to patients.

Like antipsychotic drugs, nicotine is metabolised by a cytochrome enzyme complex (CYP2A6). In past years, much attention has focused on the effect of functional variants of the CYP 2A6 gene on smoking status (Pianezza et al, 1998). More recent studies have also highlighted the potential of applying pharmacogenetics in clinical addiction services; women receiving nicotine replacement therapy (NRT) possessing a variant of dopamine receptor 2 gene (DRD2) were shown to have significantly different success rates with NRT depending on their DRD2 genotype (Yudkin et al, 2004).

This and other findings (Lerman et al, 2002) raise the issue of screening smokers with the intention of informing them which treatments they are most likely to benefit from. With rapid advances in genomic information and high throughput genotype screening techniques, more relevant functional genomic information is becoming available. Hodgson et al correctly infer that a thorough development phase is needed before this approach can be translated into widespread clinical applications.

In addition it will be important to protect patients against possible premature exposure to private genetic screening and advisory services using preliminary genetic findings which may not be substantiated through rigorous replication studies. With the realistic possibility of commercial involvement in gene based diagnostics, patients may be exposed to marketing strategies offering tailored smoking cessation therapies, based on preliminary/incomplete study results.


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Why do psychiatric patients wait too long in A&E?

By December 2004, all patients must be discharged from an accident and emergency (A&E) department within 4 hours of arrival (Department of Health, 2001). We sought to identify what factors contributed to the long waiting times experienced by some patients referred to psychiatry by our local A&E department. We identified 23 patients who breached the 4-hour target. More than half were patients who had self-harmed. Alcohol intoxication and awaiting the results of investigations following an overdose were common reasons for a delay. In more than a fifth of cases, a prolonged psychiatric assessment was required, including one Mental Health Act 1983 assessment. In 40% of cases, there was more than an hour’s delay between referral and psychiatric assessment.

A rapid response is unlikely to reduce attendance to below 4 hours in all cases. If a psychiatrist can attend within 1 hour, and their assessment takes no more than another hour, then patients should be referred within 2 hours of attendance to achieve the 4-hour target. This occurred in only one-quarter of cases reviewed.

Striving to achieve rapid throughput for patients with psychiatric as well as physical problems may not always be possible or advisable (Psychiatric Bulletin, December 2003, 27, 81–82). Obtaining background information is often a crucial but time-consuming part of an assessment. Is the drive for a rapid discharge from A&E, evidence of a sway towards ‘fast psychiatry’ (Psychiatric Bulletin, July 2004, 28, 265–266) that runs counter to good clinical care?


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