Communication skills of overseas doctors and training implications for psychiatry

The ability to communicate effectively is fundamental for a doctor practising in any medical specialty, and it assumes crucial importance in psychiatry. Good communication between doctor and patient is necessary for history-taking, eliciting symptoms of mental illness, exploring sensitive issues and establishing rapport with patients. Proficiency in the English language may not be sufficient in understanding its subtleties and nuances.

The General Medical Council (GMC) guidelines state that doctors should have adequate language and communication skills to practise in the UK, involving submission of an original International English Language Testing System (IELTS) certificate, showing attainment of minimum scores in speaking, listening, reading and writing English (www.gmc-uk.org/doctors/registration/applications/join_the_register/language___proficiency.asp). In 2008, just 6% of candidates sitting Paper 1 of the Membership of the Royal College of Psychiatrists examination were UK graduates (www.rcpsych.ac.uk/member/rcpsychnews/august2008.aspx).

A majority of psychiatry trainees for whom English is not their first language have received training overseas.

A qualitative survey was conducted to gauge the opinions of trainers, trainees and service users regarding communication skills of overseas doctors. Self-report questionnaires addressing communication and language were completed by a sample of consultant trainers, psychiatry trainees and service users of Greater Manchester West Mental Health NHS Foundation Trust. Questions addressed issues regarding effective communication, language ability, impact on patient care and training implications for psychiatrists.

There were 99 respondents (11 trainers, 15 trainees and 73 service users). Trainers perceived the need for additional training for trainees if their language skills were deficient. They suggested that a system for assessing language competency should be provided by the Royal College of Psychiatrists. Trainees reported a high level of English language competency, but regarded IELTS as not meeting the requirements for training in psychiatry. They also suggested additional training components and language testing to be introduced by the College and the GMC. Service users who had been seen by overseas doctors perceived them to be good communicators with minimal language difficulties. They also felt that doctors who had problems speaking English should receive additional training.

Although overseas doctors’ language competencies are regarded as being adequate by trainers, service users and trainees, additional formalised language training is felt to be necessary. This should be recognised by the GMC and the Royal College of Psychiatrists. Localised language training should be facilitated and encouraged as part of skills development and should be assessed through regular workplace-based assessments.

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Dealing with transphobic harassment: the experience of a transsexual in-patient

Up to 33% of female in-patients on psychiatric wards experience unwanted sexual comments and pestering of women patients is also common (56%). Harassment has been a particular problem for one our patients, a male-to-female transsexual who required admission for depression and suicidal thoughts. She has found hospital admission particularly difficult both due to prejudice from fellow patients and because of what she describes as ‘transphobic’ abuse from staff. Even during the first hours of her admission it became clear that our in-patient service was not going to find it easy to meet her needs and she was moved between wards, allocated a bed in a female area, then in a male area, and then finally moved to a single bedroom in a mixed ward.

Although these were real practical issues (i.e. trust wards operate either as same-gender wards or as wards with specific male/female areas with gender-specific bathrooms), it also seemed that staff’s attitude was a major factor in the patient’s feeling harassed and discriminated against. Following a complaint to management she has agreed to meet with ward managers to discuss the issues. Helpfully for the medical staff, the patient also agreed for her case to be presented at the academic programme to which all grades of doctors attend. She preferred to be present throughout the presentation of her history, talked of her own experiences and participated in the subsequent discussion.

A questionnaire survey of the attendees at the presentation revealed that most understood the difficulty experienced by the patient and appreciative the issues of harassment and discriminatory practice as she described them. The majority (76%) had no training in transgender issues and would welcome some.

The Department of Health guidelines on transgender issues do not specifically refer to in-patient accommodation but are more focused on staff attitudes.

It would be interesting to see whether in-patient accommodation would prevent the harassment described by our patient or whether staff awareness is the more vital component.

1 Lawn T, McDonald E. Developing a policy to deal with sexual assault on psychiatric in-patient wards. Psychiatr Bull 2009; 33: 108–11.


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Xenophobia: a new term in psychiatry?

Studying the international literature in psychiatry and the publications in psychiatric journals, we could not identify
any simple term that could describe ‘strange’ speech.

Currently there are terms that only partly describe what we wanted to be included in a single general term. For example, schizophrenic speech is composed of unusual oral creations which cannot be considered as a language as the latter is nothing if it is not creative. The term ‘schizophrenia’ designates, specifically, at least two forms of unconventional surface speech behaviours – ‘glossomanic behaviour’ and ‘glossolalic behaviour’ – that can be observed in certain patients who experience a psychotic episode. Both can be spectacular. The essential characteristics of ‘glossolalic schizophrenia’ is the production of utterances the linguistic components of which – be they phonemes, words or more complex units – are selected and combined on the basis of superficial or semantic kinships rather than an immediately shareable topic. The main characteristic of ‘glossolalic schizophrenia’ is an entirely or nearly entirely neologistic discourse.

However, the Greek term xenophonia describes what we are looking for. The exact definition for xenophonia is any strange/oddly/paradoxical voice or speech and xenophonic is one who speaks or sounds strange. Following a thorough research of all available databases, including EMBASE, MEDLINE and PsychINFO, without any language restriction, the term xenophonia has been referred to in only one paper, a non-psychiatric study. It is being used there to describe a vocal abnormality during and after the sound variation stage; the main symptoms are high tone, low voice, short breath and unstable sound control, which are usually a functional variation, a habitual vocal defect.

As the term xenophonia has never been mentioned in our fields of interest we would like to propose it as a new psychiatric term which describes the phenomena of generally ‘strange speech’.


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ECT: there is more than just unilateral or bilateral selection!

The assumption that all doctors are well informed about the latest arguments regarding the pros and cons of unilateral or bilateral electroconvulsive therapy (ECT) may not be right. We would like to take this opportunity to update readers of current developments that may potentially revolutionise or even significantly modify our thinking about this controversial treatment.

As the author says, the UK ECT review group in 2003 had an important short-coming of inclusion of all stimulus intensities, leading to a dubious conclusion in favour of the advantages of bilateral ECT.1 Although we do believe that the uncertainty in evidence exists, the emerging evidence base, particularly in the USA and Australia, may tilt the balance of opinion and attitudes, more in favour of right unilateral (RUL) ECT with the ultra-brief type of pulse width.

Sackeim et al2 and Loo et al3 have in 2008 published research indicating that ultra-brief pulse width right unilateral ECT is likely as effective as the conventional one (brief pulse RUL), in addition to being significantly better in terms of cognitive disability. This is an exciting new development as we believe cognitive disability has consistently been underplayed in studies on ECT over the years. Robertson & Pryor4 as well as Mangoong & Lucy5 cite extensive relevant body of research suggesting a lot more cognitive damage and disability, undetected by conventional testing. Additionally, if the patients were to be made aware of a potential modality of treatment with significantly less cognitive disability, they may actually make a more completely informed decision.

Although it is not difficult to adapt current practice to using ultra-brief pulse width RUL ECT by slight modification of the ‘programmes’ settings available on current machines in the UK, this detail is clearly beyond the scope of this letter. In conclusion, we posit that the need for faster recovery by using bilateral ECT may be more than balanced by the need to deliver the treatment that is less disabling (in terms of cognitive disability) and possibly equally effective.

3 Loo CK, Sainsbury K, Sheehan P, Lydon B. A comparison of RUL ultrabrief pulse (0.3 ms) ECT and standard RUL ECT. Int/ Neuropsychopharmacol 2008; 11: 883–90.

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A survey on takeaways in a secure unit

Physical health monitoring of long-term detained psychiatric patients in secure care has attracted much attention in the past few years. The rate of coronary heart disease in patients with schizophrenia is almost three times higher than in the general population and is thought to be a greater contributor to mortality in this group of patients than suicide. Patients on antipsychotic medication seem to have a worse metabolic profile. The metabolic syndrome has been described as a risk factor associated with the development of coronary heart disease and includes central obesity, impaired glucose tolerance, hypertriglyceridaemia, hypercholesterolaemia and hypertension. For long-stay patients in secure hospitals a combination of antipsychotic medication, poor diet, sedentary lifestyle, lack of exercise and leave, smoking and illness effects are all likely to contribute to weight gain and metabolic syndrome. As part of a wider consultation exercise promoting healthy lifestyles, concern has been raised about the number of takeaways ordered by detained patients within a National Health Service (NHS) medium secure unit and how this may contribute to metabolic syndrome. A survey monitored the number of takeaways delivered to the unit over a 21-day period.

In total, 326 individual takeaways at the overall cost of £2736 were consumed at an average of £8.40 per order (range £3–32). The figures included ‘group bookings’ from two wards within the learning disability directorate that have two designated takeaway nights per week.

It was estimated that around three-quarters of patients ordered a takeaway during the study period: 29 patients consumed at least one takeaway a week and 16 patients consumed at least

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two per week; 4 patients consumed a takeaway every other day and 1 patient consumed 15 takeaways in total. There was no clear distribution between acute and rehabilitation wards and there were no obvious gender differences. The mean number of takeaways per ordering patient was five. At least half of the takeaways were curries.

The wide range of cost and high average cost probably reflected group bookings registered to a patient and so underestimated the total number of takeaways. This was confirmed at a unit meeting with patient representatives who felt that a takeaway should be on average cost around £5 and that sharing takeaways or group bookings registered to a patient occurred frequently. If extrapolated over a year, a patient would spend on average £727 on takeaways. The annual cost for all patients in the unit would be £47,422.

Possible ways of reducing ‘excessive takeaways’, though this amount is underestimated, include individual care plans or designated ‘takeaway nights’, which is the current policy within the learning disability directorate. Although the average number of takeaways per patient was five within a 21-day period and could potentially increase to six if takeaways were ordered twice a week, as per the learning disability model, it was felt that the average number of takeaways calculated was a gross underestimate. An outright ban could be enforced on security grounds. The issue of restricting patient choice, patient autonomy, poor-quality hospital food and infringing on human rights have been raised as counterarguments.

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Injectable opioid prescribing in Oxfordshire

We sought to replicate in the Specialist Community Addiction Service that covers the county of Oxfordshire the audit on the prescribing of injectable opiates undertaken by White & Shearman in Cornwall.1 We identified 19 patients (14 males and 5 females) on regular injectable opioid prescriptions: 10 on diamorphine (53%), 5 on methadone (26%), 2 on pethidine (11%) and 1 on morphine (5%); 1 person dropped out of the service and was not further included in the study. Of these, 17 were interviewed using a slightly modified version of the audit tool kindly provided by White & Shearman. Only one person had been started on a script in the past 4 years while others had been on this type of treatment for an average of 9.5 years (s.d. = 4.1). Three patients, all females, had been dependent on prescribed injectable opioid analgesics. The other 14 had been heroin users for an average of 15.8 years (s.d. = 6.3) before being started on an injectable prescription. Compared with Cornwall, our audit reveals an older group of users who had been started on injectable scripts after lengthy periods of oral substitution treatment (average 9.2 years, s.d. = 6.1). The Oxfordshire cohort was also relatively more stable with no reports of overdoses while using the prescribed drug or additional opiate use in the previous month. Alcohol consumption was also low, with only two clients reporting problematic levels of drinking. When asked, 47% said they had no intention to ever come off the script; 29% would consider it in 5 years and 24% in 1 year. The clients, regardless of the drug injected, were approximately evenly split between almost exclusive intramuscular or intravenous use with little crossover. Around half the patients reported experiencing any harmful physical consequences from prescribed injectable opiates. Occasional abscesses were the main problem faced by those injecting intramuscularly, whereas those who practised intravenous injections reported abscesses, deep vein thrombosis and cellulitis. All had found access to medical care when needed. The overwhelming majority claimed to consistently use clean needles but the answers were more equivocal with regard to sterile injecting technique. Direct supervision of injecting techniques was minimal with only two clients (11%) remembering having been observed on one occasion by their general practitioner or another health professional. In conclusion, we found interesting similarities between the client groups in Oxford and Cornwall, which might indicate that a clinical rationale for providing injectable opiates to a niche population exists and that it transcends geographical and social regional differences.

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Prevalence of challenging behaviour among older in-patients: a pilot study

Older people occupy two-thirds of in-patient beds in acute general hospitals. Pre-existing mental health disorders are independent predictors of poor outcomes such as increased mortality and length of stay, loss of independent function and higher rates of institutionalisation.1 Disruptive behaviour can have a negative effect on the nursing and other healthcare staff and can affect the quality of care provided to other patients on the ward.2 There are no published studies on the prevalence of behavioural problems in older in-patients in the UK.

We conducted a pilot study to determine the prevalence of challenging behaviour in older people on two care of the elderly wards in an acute general hospital. Patients aged 65 years and older were included. The Crichton Royal Behavioural Rating Scale (CRBRS)3 was used to identify patients with challenging behaviour. The CRBRS is a descriptive scale designed to assess patients on psycho-geriatric wards. The main scale items are mobility, orientation, communication, cooperation, restlessness, dressing, feeding, mood and continence. Each modality has a score of between 1 and 5, where 1 is normal and 5 is the most abnormal. The scores for cooperation, restlessness and sleep are those that provide information on the prevalence of challenging behaviour. Patients with a score of 2 or more for restlessness or sleep, or 4 or more for cooperation are considered to have a challenging behaviour.

The scale was completed separately for daytime and night-time by interviewing nursing staff completing the respective shifts. Medical notes were examined to identify any previous mental health problems and to determine whether the patients were on psychiatric medication. The study was approved by the trust’s clinical governance department. In total, 58 patients were studied (47 males). Mean age was 81 years (range 66–96). Challenging behaviour was identified in 16 patients (29%) according to the CRBRS criteria: 5 scored for restlessness only; 3 for restlessness, sleep disturbance and cooperation; 1 scored for sleep disturbance and cooperation, and 1 for...
sleep disturbance only. Of the 58 patients studied, 21 had a known psychiatric history before admission (14 dementia, 6 depression, 1 schizophrenia). Of the 16 patients with challenging behaviour, 8 had dementia and 1 had schizophrenia; 6 patients did not have a history of a psychiatric disorder. A history of dementia was significantly more common among patients with challenging behaviour ($P = 0.008$). Aggressive behaviour was seen in 48% of patients in this group and was not seen among patients not scored to have challenging behaviour. Wandering was seen in 25% of patients with challenging behaviour.

We conclude that a significant number of elderly patients admitted to our hospital had challenging behaviour. Dementia seemed to be associated with challenging behaviour, and aggressive behaviour was seen in a significantly large proportion of patients. A larger study is warranted.

1 Working Group for the Faculty of Old Age Psychiatry. Who Cares Wins. Improving the Outcome for Older People Admitted to the General Hospital: Guideline for the Development of Liaison Mental Health Services for Older People. Royal College of Psychiatrists, 2005.


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