the columns

correspondence

Stigma of mental illness among Chinese people

I read with interest the paper by Chung & Wong 'Experiences of stigma among Chinese mental health patients in Hong Kong' (*Psychiatric Bulletin*, December 2004, **28**, 451–454). They cited as one limitation of their study that their results might not extrapolate to the Chinese population in other countries. A preliminary assessment of the mental health needs of Chinese young people in Birmingham, UK (Chinese National Healthy Living Centre, 2005) revealed that stigma remains an important issue among Chinese in the UK. The assessment concluded that the majority of Chinese young people and their parents perceive mental illness as being 'crazy' and associated with violence. This finding agrees with the conclusion of Chung & Wong's paper that many Chinese patients have experienced stigma and discrimination in Hong Kong.

Chung & Wong stated that the term 'mental illness' can be associated with stigma, yet they used the same term in their study questionnaire. In their clinical implications section, they have sensibly replaced the term 'mental illness' with 'mental health problems', which is a less stigmatising term. Their findings might have been more positive if they had used the term 'mental health problems' instead of 'mental illness' in their questionnaire.

CHINESE NATIONAL HEALTHY LIVING CENTRE (2005) *A Preliminary Assessment of the Mental Health Needs of Chinese Young People in Birmingham*. Birmingham: Chinese National Healthy Living Centre.

CHUNG, K. F. & WONG, M. C. (2004) Experience of stigma among Chinese mental health patients in Hong Kong. *Psychiatric Bulletin*, **28**, 451–454.

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Cranial computed tomographic scans in elderly people – how often do they influence clinical management?

Fielding's study 'The value of cranial computed tomography in old age psychiatry: a review of the results of 178 consecutive scans' (*Psychiatric Bulletin*, January 2005, **29**, 21–23) assessed the value of cranial computed tomographic (CT) scans in the elderly population and evaluated the recommendations of the Royal College of Psychiatrists on the selection of patients for scanning. However, the article was erroneous in stating that the College recommends all patients to be scanned unless the 'history is typical OR history greater than 1 year'. The College in fact recommends that all patients receive a scan 'unless the patient has a history of more than a year AND there is a typical clinical picture' (Royal College of Psychiatrists, 1995).

The author concluded that the study added validity to the College's criteria and suggested that cranial CT scans might influence patient management. I conducted an audit review of 56 cranial CT scans in elderly people. In 51%, clinical management was not influenced by the CT scan. This group included those who were unwilling to receive treatment. Fielding stated that the prevalence of truly reversible causes of dementia identified by cranial CT is extremely low. In support of this, in my audit review none of the scan results showed evidence of potentially reversible causes of dementia.

FIELDING, S. (2005) The value of cranial computed tomography in old age psychiatry: a review of the results of 178 consecutive scans. *Psychiatric Bulletin*, **29**, 21–23.

ROYAL COLLEGE OF PSYCHIATRISTS (1995) *Consensus Statement on the Assessment of an Elderly Person with Suspected Cognitive Impairment by a Specialist Old Age Psychiatry Service* (Council Report CR49). London: Royal College of Psychiatrists.

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Malignant alienation

I read with interest the letter by Darryl Watts 'Malignant alienation – a concept that has not yet arrived' (*Psychiatric Bulletin*, December 2004, **28**, 459). I also read the earlier editorial on malignant alienation by Watts & Morgan (1994). It would appear to me that the term 'malignant alienation' does describe a group of patients who according to Watts and Morgan are 'hard to like'. I believe that quite a number of these patients overlap with persons who would now be diagnosed with Asperger syndrome. The major problems in relationships with others, and the loss of sympathy from staff who perceive their behaviour as being unreasonable, would fit with Asperger syndrome. It is hardly surprising if this continues that there could be a suicidal outcome. I would suggest that patients with this description 'malignant alienation' be assessed for Asperger syndrome.

WATTS, D. (2004) Malignant alienation – A concept that has not yet arrived? *Psychiatric Bulletin*, **28**, 459.

WATTS, D. & MORGAN, G. (1994) Malignant alienation: Dangers for patients who are hard to like. *British Journal of Psychiatry*, **164**, 11–15.

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Do we really need a duty consultant?

Do consultant psychiatrists really need to provide a conventional out of hours service? How often does a clinical insight, resulting from a face-to-face, out-of-hours interview with the duty consultant psychiatrist, genuinely contribute to the management of a situation, in a way that could not have waited until the following day? Between 17.00 h and 09.00 h, could it not be replaced by telephone advice? A single consultant (working a reasonable shift of say 8 h) could provide advice to junior doctors, and others, for a large catchment of several million people, with a local consultant still available to review patients between 09.00 h and 17.00 h on weekends and public holidays.

There are two strong arguments for making such a change. First, the effort and expenditure invested by the National Health Service in ensuring the physical presence of a consultant psychiatrist at all times could be better spent on other service developments. Second, recruitment and retention are major challenges for the psychiatric profession (Storer, 2002) and we compete with other specialties for

https://doi.org/10.1192/pb.29.5.193-c Published online by Cambridge University Press

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recruits. A significant attraction of psychiatry has traditionally been its 'family friendly' image (Eagles, 1996). The new general practitioner (GP) contract, with GPs no longer *obliged* to work out of hours, is likely to have significant effects on recruitment and retention in psychiatry. Psychiatry competes with general practice for recruits, and general practice has become much more attractive.

EAGLES, J. M. (1996) Gender differences in attitudes and recruitment into psychiatry. *Psychological Reports*, **78**, 653–654.

STORER, D. (2002) Recruiting and retaining psychiatrists. *British Journal of Psychiatry*, **180**, 296–297.

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Obituary of Tom Lambo

The obituary of Tom Lambo (*Psychiatric Bulletin*, December 2004, **28**, 469) prompts me to explain why so many Birmingham graduates have achieved distinction in psychiatry. A rough survey would include, among others, the names of Leishman, Gunn, Cawley, Merskey, Rutter, a number who collected in Oxford and several who returned to their native countries such as Australia and New Zealand. This was largely due to the structure of the department. From the start it was a part of the Division of Neurological Studies, which included Neurology, Neurosurgery, Neuropathology and Neuroradiology. We were able to get recruits through their house jobs, for psychiatry was linked with neurology. These 'house' jobs were recognised as registrable 'house jobs'. It proved a useful recruiting measure, for such exposure gave the young doctor a chance to compare a career in psychiatry with the other specialties. This arrangement was promoted by Professor Cloake who chaired the Department of Neurological Studies. He was a distinguished neurologist who also had a good grounding in psychology. He backed me in obtaining the resources for a first-class out-patient department and later a day hospital, which compensated for the relatively few beds we had. Contact with general medicine was encouraged and attendance at the medical grand rounds was mandatory, and cases were presented. The late Sir Aubrey Lewis, who was on a national trip to assess the future of psychiatry in teaching hospitals, was on his final visit in Birmingham. He told me that our department was the best integrated in the country. I asked him how he could come to such a conclusion and he told me that he would meet the surgeons and physicians and ask whether they would prefer to have their own building apart from the general hospital; Birmingham was the only medical school where there was unanimous support for retaining an integrated system as they valued the services we provided and were enthusiastic about the close contact we had in teaching in the medical and surgical wards.

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https://doi.org/10.1192/pb.29.5.193-c Published online by Cambridge University Press