possible that antipsychotic medication was the initial intervention used and the patient took it as a matter of routine.

In summary, medication adherence is a complex issue that can be affected by various factors, such as lack of insight, religious and cultural beliefs, level of education and socio-economic status, comorbid alcohol misuse, to name a few.[4] We believe further studies are needed in this area.

1 Perecherla S, Macdonald AJD. Older psychiatric in-patients' knowledge about psychotropic and non-psychotropic medications. *Psychiatrist* 2011; **35**: 220–4.

2 Mitchell AJ, Selmes T. Why don't patients take their medicine? Reasons and solutions in psychiatry. *Adv Psychiatr Treat* 2007; **13**: 336–46.

3 Droulout T, Liraud F, Verdoux H. Relationships between insight and medication adherence in subjects with psychosis. *Encephale* 2003; **29**: 430–7.

4 Patel MX, David AS. Medication adherence: predictive factors and enhancement strategies. *Psychiatry* 2007; **6**: 357–61.

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Authors' response: We agree that adherence to medication is important and subject to complex influences. We thought that understanding of medication was a neglected factor and set out to study this rather than adherence. We had hoped that this was clear. We were surprised to find that, broadly speaking, patients understood psychotropic and non-psychotropic medication to the same degree. We confirm that patients from ethnic minorities who were able to speak English were included; patients were in acute wards and not long-stay wards (of which we have none). In the example of how we chose which medication to ask about, we do not say that we selected the mood stabiliser over the antipsychotic because it was given first. We chose it because it was likely to be used for the longest time. We agree that our sample was not representative of all older psychiatric patients and say as much in the discussion.

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Recruitment in psychiatry

Those concerned about the dearth of young doctors applying to train as consultant psychiatrists might usefully consider the motives of those who make this choice. I am a recently retired general adult consultant psychiatrist that worked in England. I chose to undertake training because I wished to emulate senior consultants whom I met while acting as a medical student or junior doctor. I admired their determination and aspiration to improve the lives of those suffering from serious mental illness and their central role in the clinical care of those referred to mental health services. However, I fear junior doctors will now find it difficult to meet such inspirational and dynamic clinicians.

In England the blame culture consequent on the repeated internal, coroner and external enquiries, reconfiguration of services, the provisions of the amended Mental Health Act and New Ways of Working for consultants psychiatrists (and others) have all undermined morale. This last development left me without responsibility for my in-patients, the autonomy to arrange urgent admission when I thought this necessary or, in some cases, to refer for appropriate psychological therapy. Working became an increasing challenge. Our junior doctors notice these developments and their effect on senior colleagues' attitudes. It does not surprise me that the number opting to train remains worryingly low.

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Retaining trainees in psychiatry through a more mindful practice

Barras & Harris's survey on retention difficulties in psychiatry[1] in provoking further discussion about the state of psychiatric training is an important piece of work. The systemic effects of the current economic crisis cannot be separated out from implications to services and in turn their impact is felt by those working and training within the system. Having myself recently completed higher training in psychotherapy, and through my experience of facilitating trainee case-based discussion groups, many of the trainees' comments picked up by Barras & Harris felt all too familiar.

In terms of trainee concerns over the attitude of others towards psychiatry, I very much agree with the thinking of the authors that better integration of psychiatry with other specialties may increase understanding of both the contribution of psychiatry and challenge of mental health difficulties. Alongside this, I also think it is important to recognise that to bear with the projected 'madness' of others, which may mean we are seen as unsettling and to be kept a distance from perhaps by devaluation, is an important function of psychiatrists. Trainees' function as containers can be fostered, for example, in case-based discussion groups, enabling them to begin to understand and tolerate some of these processes as they are played out in their day-to-day work.

In Barras & Harris's study, when asked about work and patient care, trainees complained about too much paperwork and a pressure to appear to be 'doing things correctly', which both undermine the real patient care. The concept of social defence, as described by Menzies-Lyth in her study of poor medical nursing staff retention in hospitals,[2] is helpful in thinking about some of these difficulties. In mental hospitals, working practices which reduce contact with patients, such as the care of an individual patient being split into tasks or reduplication of checks to eliminate or share the responsibility of decisions, are used by staff/managers because of a fear of being in contact both with patients' and their own 'mad violence' and fragmentation. Further to this, the additional pressures of restructuring may both add to and be part of the same process. Ballatt & Campling in *Intelligent Kindness*[3] remind us that 'there is certainly evidence that major structural change keeps senior managers and board members detached from the front line of healthcare' (p. 131). In the face of this poor containment by the organisation, it is not surprising that morale is low among trainees.