Enticing GP trainees

Dein et al’s article (Psychiatric Bulletin, June 2007, 31, 227–230) is fascinating and worrying, given recent developments in the structure of training rotations. The authors emphasise the importance of exposure to psychiatry after medical school, and that it is too soon to evaluate the impact of the foundation year. Previously, the main opportunity for postgraduate exposure was through GP vocational programmes. In many parts of the country, as a consequence of MMC/MTAS, such programmes have expanded: for example, in the South East, excluding London, the balance between psychiatric and GP trainees has shifted massively in favour of the latter, with over 80 posts being ‘converted’ this summer. However, simultaneously, 6-month training slots have been reduced now to 4 months’ duration, to meet the needs of the GP rotations. I question whether 4 months’ exposure is enough to encourage GP trainees to switch to psychiatry, as has been common in the past. Rather, the structure of the new senior house officer (SHO) jobs, which have moved towards being generic site duty doctors for in-patient units, while the committed psychiatric trainees staff the more interesting community and specialist jobs, is I believe less likely to contribute to the important postgraduate factors of empathy, better working conditions and a sense of fulfilment with improvement or interface with other disciplines.

If we wish to encourage GP trainees to switch to psychiatry, we need urgently to rethink what we provide during their brief 4-month exposure so that it makes a lasting and positive impression, not treat them as workhorses passing briefly through.

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Improving prescription quality in an in-patient mental health unit

We read with interest the evaluation of prescription quality on an in-patient mental health unit by Ved & Coupe (Psychiatric Bulletin, August 2007, 31, 293–294). We have recently completed an audit of prescription quality of ‘as required’ medication on our acute psychiatric in-patient ward. All prescription charts (n=90) over a 1-month period were audited, incorporating 282 prescriptions. Similar results were noted to those in the first cycle of the clinical audit by Ved & Coupe (2007). However, we had lower rates of generic prescribing (43 v. 96%) and the reason for prescribing ‘as required’ medications was stated less frequently (17 v. 52%). There is a culture of non-generic prescribing in Ireland compared with the UK, most probably fuelled by differing legislation with regard to prescribing liability and dispensing of medications (McGettigan et al, 1997). We had higher rates of cancelling medications correctly (78 v. 40%).

Unlike Ved & Coupe (2007) we assessed whether nursing staff recorded administering ‘as required’ medications to patients in the nursing notes after signing for them in the prescription chart and found that they did in 57% of cases. In 90% of these cases an explanation was documented. Nurses were far more likely to record administering psychotropic than non-psychotropic medication (70 v. 22%, P<0.0001).

Both our study and that of Ved & Coupe (2007) demonstrate that the quality of prescribing can be improved and we agree that continuous quality assurance requires ongoing data collection, review of those data and action. The greatest deficits in prescription quality in our acute in-patient unit were in prescribing medications generically and stating a reason for prescribing ‘as required’ medication.


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OSCE: experience as a simulated candidate

Philip Seager’s letter (Psychiatric Bulletin, August 2007, 31, 316) about performing