teaching. On top of this, individuals have to fit in a healthy work–life balance.

During training, I decided that sectorised jobs involved too many competing demands. I opted to work only with in-patients as a part-time consultant. Unfortunately, many trusts that I approached for jobs struggled to accommodate this style of working.

I have been able to take advantage of an opportunity offered by National Health Service professionals. I started in February on the New Consultant Entry Scheme, which offers a 6-month trial with support, mentoring and extra continuing professional development time. There have been teething problems but the chance to try out newer ways of working on a trial basis seemed less risky than committing to a substantive job only to walk away.

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Melatonin use in children


Several studies they mentioned were with blind subjects. It is important to consider that blind people have free-running circadian rhythms that are not amenable to the most powerful of resetting cues – light.

The use of melatonin to trigger the new 24-hour period is very powerful in this patient group.

Charles D. Pickard et al (2000) showed that low levels of melatonin, 0.5 mg, reset rhythm but not high doses, 2 mg. The prolonged half-life of melatonin and the sensitivity of the circadian rhythm to its presence mean that in trying to achieve phase advancement (bringing sleep forward to combat ‘sundowning’ in the elderly) or delay (delaying sleep onset to combat ‘jetlag’) melatonin has a window effect. Too low a dose and no effect, too high and the chronobiological effects are lost and the direct somnolent action is experienced. It would be a shame if a potentially useful treatment for circadian rhythm disorders, including sleep disturbances and seasonal affective disorders, were discarded prematurely due to a perceived lack of efficacy.

Declaration of interest

The author uses melatonin to reduce recovery time from intercontinental jetlag: personal use only.


Cannabis reclassification

On 29 January 2004, cannabis was reclassified using the groupings of the Misuse of Drugs Act 1971 from Class B to Class C. As well as the increasing evidence that the drug is harmful to both physical and mental health, which has been recently highlighted (Henry et al, 2003; Rey & Tennent, 2002) this has caused confusion and concern regarding its legal position. This has been highlighted in articles on TV, broadsheet (‘Cloud of confusion over cannabis’, Daily Telegraph, 23 January 2004) and tabloid newspapers (‘Pot a joke’, The Sun, 23 January 2004).

We would like to report our deep concern that this confusion may extend to the medical student population, 3 days after the reclassification.

As part of an evaluation of a substance misuse lecture given to first-year medical students at Sheffield University, 163 completed an evaluation form (62% response rate) (fig. 1). When asked if smoking cannabis at home by yourself was illegal, 42% of the respondents answered incorrectly that it was not.

Eighteen per cent were under the misapprehension that smoking cannabis in a public place was not an arrestable offence. Surprisingly, given the publicity, 41% did not know the drug class cannabis resin belonged to.

Further questions in the evaluation related to other drugs, their purchase and means of administration. We highlight these findings because cannabis is known to be the most widely used illegal drug among medical students (Pickard et al, 2000), with reports of 54% of males and 40% of females using at least once (Webb et al, 1998).

If this surprising level of ignorance exists in medical students, we wonder what the understanding of the rest of the population is. This is especially important given that those of a similar age to our students are most likely to use cannabis, the government’s own data showing that 44% of 16–29 year-olds have used the drug (Home Office, 2000).


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