the columns

correspondence

Helping the recruitment cause in psychiatry: a postmodernisation promise

Boyle *et al*[1] have highlighted some of the important positive aspects of foundation year placements in influencing career choice into psychiatry. The jubilant article carries an optimistic account from trainers and trainees who share the champagne of successful mentoring. Unfortunately, the darker side of wider experience while seeking foundation placements in psychiatry has been overlooked.

The number of places available for FY1 and FY2 placements in psychiatry are very limited, and as of now not representational of subsequent requirements the specialty has during core training. There is an urgent need for such 'potential demand' *v.* supply statistics to be made clear and compared across various specialties. The perennial recruitment issue could be seen in correct perspective when level playing fields are ensured following the implementation of Modernising Medical Careers.

Despite being a trainee with significant interest in exploring psychiatry as a career choice, the placements in my current FY2 rotation were ready-made with no element of choice. On the wake of Boyle *et al*'s account, it is important to solicit and analyse national data on foundation placements in psychiatry and rate of conversion into core psychiatric training. Creating such foundation maps of potential psychiatry placements across deaneries may help interested trainees to plan their careers. One could argue that psychiatry must be given more foundation slots than some relatively oversubscribed specialties.

If one is allowed to make a deduction from personal experience, most specialties look at foundation doctors as inconsequential cogs in the churning wheel of hospital machinery. Very few minutes in the 120 days of a foundation placement are spent in motivating the trainee to consider a specific specialty career. In addition, the educational meetings and professional activities in most hospital units tend to concentrate either on core trainees or making a 'safe doctor' out of foundation trainees. There is an immense hidden potential for psychiatry to convert a substantial number of hesitant doctors into promising and passionate specialists for the future, if some collective and timely effort is taken to recognise the prospect here.

Bearing in mind that at least a quarter of all psychiatrists explore other specialties before choosing psychiatry as their career,[2] making foundation year psychiatry more accessible will serve our recruitment cause a great deal.

1 Boyle AM, Chaloner DA, Millward T, Rao V, Messer C. Recruitment from foundation year 2 posts into specialty training: a potential success story? *Psychiatr Bull* 2009; **33**: 306–8.

2 Dein K, Livingston G, Bench C. 'Why did I become a psychiatrist?': survey of consultant psychiatrists. *Psychiatr Bull* 2007; **31**: 227–30.

Priyadharshini Sabesan Foundation Year 2 Doctor, Department of Obstetrics and Gynaecology, Pilgrim Hospital, Boston PE21 9QQ, email: priyasabesan@gmail.com, **Lena Palaniyappan** Clinical Lecturer and Honorary Specialist Registrar in Psychiatry, University of Nottingham

doi: 10.1192/pb.33.12.480

Home visits for older people: a practical model outside Yorkshire

Professors Benbow & Jolley invite us to 'set the record straight' in agreeing with them that 'in many good services for older people home visits are the reality'.[1] We are pleased to concur with them and refer them to the title of our paper.[2] However, they appear to be confusing 'community clinics' with community-oriented mental health services.

In her original paper,[3] Professor Benbow described replacing a psychiatric out-patient clinic with what she designated a 'community clinic', whereby the catchment area was divided into four geographical areas, each being visited by the psychiatrist once every 4 weeks. To our knowledge, this model has not been adopted elsewhere, or if it has, no one has written about it in peer-reviewed journals. Elderly mental health services in Sheffield are not resourced to provide such a service. If services were reconfigured in this way, psychiatrists' time would be deflected from community mental health team (CMHT) work or other community-oriented work such as the dementia rapid response team and the (functional illness) discharge and rehabilitation team.

Our paper does not in any way suggest replacing community work with out-patients; what we are advocating is efficiently run out-patient clinics in the context of well-coordinated community-oriented services. Older patients who are independently mobile are capable of attending an out-patient department, as they do for appointments in general hospitals. For psychiatric patients who are immobile, house-bound, refusing to attend, or in residential/nursing homes, in Sheffield they are seen in their own home either by a psychiatrist or another CMHT member.

The purpose of our simple questionnaire study was to assess user and carer acceptability of attending psychiatric out-patients. The majority of older users and carers were highly satisfied with all aspects of their attendance, irrespective of the seniority of the psychiatrist seen, and we believe our findings are potentially transferable outside Sheffield.

Professors Benbow and Jolley have made a useful contribution to the literature in logging the activity of old age psychiatrists in different settings. It is equally valid to ask old users and carers of services what they think of this activity.

1 Benbow SM, Jolley D. Doctors in the house. Home visits for older people: a practical model outside Yorkshire. *Psychiatr Bull* 2009; **33**: 315.

2 Negi R, Seymour J, Flemons C, Impey M, Thomas N, Witrylak R. Psychiatric out-patient clinics for older adults: highly regarded by users and carers, but irreplaceable? *Psychiatr Bull* 2009; **33**: 127–9.

3 Benbow SM. The community clinic – its advantages and disadvantages. *Int J Geriatr Psychiatry* 1990; **5**: 119–21.

***Jeremy Seymour** Old Age Psychiatrist, Mental Health Unit, Rotherham District General, Moorgate Road, Rotherham, South Yorkshire S66 2UD, email:

jerry.seymour@rdash.nhs.uk, **Rashi Negi** Specialist Registrar in Old Age Psychiatry, **Christopher Flemons** ST4 in General Adult Psychiatry, **Matthew Impey** ST4 in General Adult Psychiatry, **NicolaThomas** ST4 in Forensic Psychiatry, **Rachael Witrylak** ST4 in Child and Adolescent Psychiatry,The Longley Centre, Sheffield

doi: 10.1192/pb.33.12.480a

Usefulness of routine blood tests in dementia work-up

Recent government reports and strategies have placed the diagnosis and treatment of dementia as a major priority within the NHS.[1] Guidelines issued from the Royal College of Psychiatrists and the National Institute for Health and Clinical Excellence on the assessment of suspected dementia suggested that all patients being referred to an old age service should receive blood tests. These include a full blood count (FBC), renal profile, liver profile, calcium, erythrocyte sedimentation rate (ESR), C-reactive protein, thyroid function tests, folate and vitamin B12.[2,3] In contrast, the Scottish Intercollegiate Guidance Network suggested that blood tests should be ordered on clinical grounds.[4]

An audit by our old age psychiatry service reviewed the laboratory and radiological results of 120 consecutively referred individuals with suspected dementia, all of whom received the blood tests suggested by the Royal College of Psychiatrists guidelines. None had reversible conditions diagnosed on computed tomography; 8.5% had low haemoglobin, 5.7% had a raised ESR, 19% had urea and electrolyte abnormalities and 14% had abnormal liver function tests. Just one patient had thyroid abnormalities and they were already on treatment for this; two had vitamin B12 and folate deficiencies and both individuals had nutritional problems due to advanced dementia.

Previous meta-analyses have shown that less than 0.6% of so-called potentially reversible dementias were reversible.[5] Our results suggest that laboratory investigations in dementia work-up are useful in the identification of medical problems that may worsen the patient's overall health or effect suitability to potential treatments. A third way should be taken between the guidelines incorporating their most useful recommendations. Simple tests like FBC, ESR, renal and liver function tests are useful in dementia work-up and should be routinely checked in all individuals with dementia. Less routine tests such as vitamin B12 and folate and thyroid function should only be completed based on clinical grounds.

1 Department of Health. *Living Well with Dementia: A National Dementia Strategy.* Department of Health, 2009.

2 Royal College of Psychiatrists. *Forgetful but not Forgotten: Assessment and Aspects of Treatment of People with Dementia by a Specialist Old Age Psychiatry Service (Council Report CR119).* Royal College of Psychiatrists, 2005.

3 National Collaborating Centre for Mental Health. *Dementia: A NICE–SCIE Guideline on Supporting People with Dementia and Their Carers in Health and Social Care.* British Psychological Society & Gaskell, 2007.

4 Scottish Intercollegiate Guidelines Network (SIGN). *Management of Patients with Dementia: A National Clinical Guideline (Scotland).* SIGN, 2006.

5 Clarfield AM. The decreasing prevalence of reversible dementias: an updated meta-analysis. *Arch Int Med* 2003; **163**: 2219–29.

***Kevin Foy** Senior Registrar in Old Age Psychiatry, Department of Old Age Psychiatry, Cavan General Hospital, Cavan, Ireland, email: kevinfoy@ireland.com, **Christian Okpalugo** Registrar, **Feargal Leonard** Consultant Psychiatrist of Old Age Psychiatry, Cavan General Hospital, Ireland

doi: 10.1192/pb.33.12.481

Postmodernism and psychiatry

We have found that 'post-psychiatry'[1] tends to challenge our patience more than it does our ontological security. We agree with Bracken & Thomas[2] in that 'an increasing number of psychiatrists are seeking to work with different frameworks and to engage positively with the diversity of the user movement'. However, we doubt that post-psychiatry has much to contribute to this effort. Holloway's commentary[3] is generous with regard to the philosophical basis of the article. We believe that the application of the confused and confusing ideas that are known as postmodernism to psychiatric practice is deeply misguided and counterproductive.

The key contention in Bracken & Thomas's article is that organised psychiatry's recent attempts to form an alliance with service users and carers are inauthentic. A true alliance, according to them, requires that we abandon the biomedical perspective in general and descriptive psychopathology in particular in order to allow us to preferentially engage with radicals within the service user movement.

They briefly mention more conventionally minded service users and carers, but effectively dismiss their point of view. This apparent lack of respect for the diversity of opinion within the service user movement is entirely consistent with the postmodernist convention that everything, including 'facts' and 'truth', is relative. Where all perspectives are equally valid, the postmodernist is free to reject objectivity as an illusion, and to confine dialogue to the like-minded. For those of us who cling on to older humanistic ideas, the challenge in getting alongside patients is to take service users' experiences and views seriously whether or not they coincide with our own. Choosing to align ourselves with one particular perspective is patronising and simply repeats the mistakes of the past.

There is an inappropriate modishness (not to mention a lack of self-awareness) in Bracken & Thomas's free use of the term 'madness'. The word remains offensive to many service users, despite the fact that a minority choose to reclaim it. It is one thing for service users to define themselves as 'mad'. It is quite another matter for mental health professionals to use such terminology. There is a parallel here with the reclamation of racist words by some Black people. There is no degree of alignment with anti-racism that makes it OK for White people to use these terms. Similarly, it is hard to see how the interests of people with mental illness are furthered by urging psychiatrists to embrace the language of bigotry.

Bracken & Thomas sustain their argument by caricaturing the biological–mechanistic approach and suggesting that it is the primary conceptual framework of psychiatry. They make assumptions as to how the profession might respond to the challenges of the more radical parts of the service user movement, but they do not reference these responses, presumably because no one has made them. Although this type of argument is common in postmodernist writing (the discourse is implicit, so the lack of explicit reference to it is irrelevant), it is hardly likely to be persuasive to anyone with a reasonable level of independent mindedness.

In a fine piece of postmodern doublethink, post-psychiatry seems to want to be both part of psychiatry and separate from it. Bracken & Thomas deny being anti-psychiatry, anti-medical or anti-scientific but they reject the existence of any objectivity that transcends a particular paradigm and they regard descriptive psychopathology as oppressive. The logical corollary of their rhetoric is that when we are helpful to patients, it is despite the fact that we are psychiatrists, not because of it. If this is the case, why involve doctors in the care of people with mental illness at all? It is simply implausible and logically inconsistent to suggest that a Royal College of Post-Psychiatrists would somehow shrug off the encultured baggage of the doctor–patient relationship to lead us to a better place where the biomedical is replaced by something which is unspecified, but nicer.

A significant part of mainstream British psychiatry has long been working to develop a more humanistic, relevant form of practice that seeks to help people to solve problems in their lives rather than