



Mind the Gap

Newsletter of the West Midlands SpR/ST4-6
General Adult Psychiatrists

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Editorial

'The Last of the Calmanites'

Dr Rehan Siddiquee

Former Chair of General Adult Psychiatry SpR/ST4-6 peer group

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Almost silently the last batch of trainees from the pre-MMC era have recently left or are close to leaving the safe confines of training to make their way into the open tumultuous waters of the modern healthcare system. It is a time that marks a change of guard in the post-graduate medical training fraternity.

It seemed only recently that the Calman report made changes to modernise and shorten specialist medical training. A process that started in the mid-nineties and was completed by the late-nineties was deemed obsolete in just a few short years. Hence, it was necessary to re-modernise medical careers once again. What ensued was unique in its scale, mainly due to the confusion and uncertainty it caused in the tens of thousands of trainee doctors in the "transitional group" all of whom by default were unemployed come August 2007. They were overwhelmed by acronyms like "MMC" and "MTAS" (which most trainees discovered was just another four letter word).

The chaos that ensued has left an entire cohort of doctors embittered and disillusioned because the system that that was foisted upon them did not even last one year before reviews were undertaken to make the "new" training more like the one it was meant to replace by implementing terms like "decoupling" (which was not even remotely linked to what most people thought it was).

Although the last Calmanites did not have to go through this process, they shared the anxiety and angst of all trainees lest they failed to enter higher specialist training before the witching hour on the 31st of December 2006.

I have heard multiple accounts from proponents and opponents, all of them much wiser and a lot more in the know than I. My simplistic (and biased) explanation is based in what some people would call "Karma." If the changes proposed to take effect in August 2007 and the process preceding it was truly well intentioned to improve training and the quality of doctors, it might have survived unscathed.



Time will tell if trainees coming out of the "new system/ revised new system/new system grafted with DNA from old system" are indeed better trained than their "Jurassic" predecessors, but some may argue that it is better to be a T-rex in a world of mammals.

[Disclaimer: The views expressed in this article by the author are not endorsed by "Mind the GAP" and at times not by the author himself]

Staying in touch

with Dr Rehan Siddiquee

Mental health news in the national and international media



The Buzz

Makers of iPhone to use exorcist to stop suicides.

Foxconn, a Chinese firm that manufactures electronic appliances for Apple amongst several other multinational companies, has had a spate of untoward incidents. There have been nine suicides in the last three months.

Digitimes reports that "Terry Guo, chairman of the Foxconn Group, has sought the aid of an exorcist in an attempt to put an end to the recent run of negative incidents at the plant."

It is more likely that poor working and living conditions at the facility are behind these attempts. Employees reportedly work 12 hour shifts and suffer living in very poor conditions in dormitories when not at work. The first reported suicide was reportedly of an employee when an iPhone prototype he was entrusted with went missing. Something to think about the next time you use your iPhone/iPad or any other gadget.

Update: It seems the exorcist was unable to stop "the negative events" as at the time of going to press the number of suicides had risen to 12. Apple, Dell and HP have all expressed concern publicly over the events with Apple considering paying Foxconn employees directly. Foxconn having tried the exorcist have now resorted to increasing the workers pay by 66%, moving 20% of its reported 800,000 workforce in Shenzhen closer to their families and using the 70 psychiatrists and 100 voluntary workers they claim to employ to stop the suicides. In a curious turn of events Foxconn has decided to stop paying families of employees that committed suicide a compensation as they believe this had encouraged some of the suicides.

(Source: Engadget)

Carrie Fisher recommends ECT

Carrie Fisher, the iconic actress who famously played Princess Leia in Star Wars, has spoken openly in several interviews about her struggle with mental illness and substance misuse.



In a televised interview on the CBS chat show "The Late Late Show" she had this to say about ECT,

"I love electro shock therapy, I love it!"

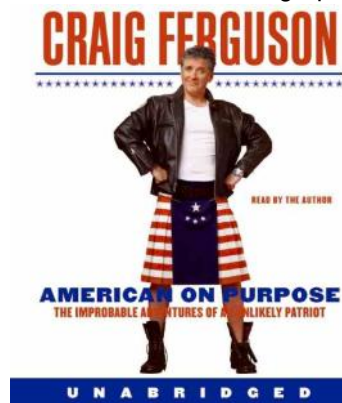
"They put you to sleep now, there are no convulsions so it shouldn't be called ECT but should be called ET but that might get confusing" (with Steven Spielberg's movie of the same name). "I was too scared to have it but am very courageous now."

When asked about the associated memory loss, Ms. Fisher candidly says, *"What will I lose in four months that I can't do in the next four months."*

(Image Source: carriefisher.com)

American on Purpose

Craig Ferguson, Glasgow born comedian/actor who is now passionately American, gives a light hearted insight into his first experience with an illicit substance at a rock concert in his autobiography 'American on Purpose'.



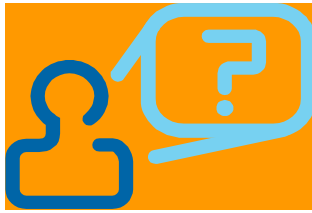
"I did start to feel pretty good, and the band sounded great! I mean, everybody was funny, hilarious in fact! And I was starting

to get a little hungry, and then really hungry.

*Karen got us hot dogs and they were the best hot dogs I had ever tasted and the band was ****ing brilliant and this was the best night of my life. It was then that I had my sudden and profound realization...from this moment on I would dedicate my life to rock n' roll, and take as many drugs as possible! What could possibly go wrong?"*

Craig Ferguson is now a famously recovering alcohol and drug ex-addict who says he has been sober for the last 18 years.





Opinion

Dilemma of New Psychiatric Registrars

by Dr Farooq Ahmed Khan
ST4 in Old age Psychiatry
Holly Hill Unit, Rubery, Birmingham

A number of things bother people when they enter into another realm of responsibility and position. It holds true for all walks of life including professional life. After being in the role of a junior doctor for a period of 3-4 years or longer, the life of a new Specialist Registrar changes suddenly. The role of following instructions changes to that of making decisions and advising other team members of professional matters. It is often confusing when we find ourselves in a position when we are not sure about something and people are waiting for our response.

I am sure this isn't a unique situation for some, but most people would agree that decisions are to be made on the spot when you don't have much time to buy. In the role of a junior doctor you always have someone to look for, ask and depend on for the 'final decision' but in the new role of a Specialist Registrar you are asked about your opinion and decision, which might be final.

There are a number of challenges the new Registrar will be faced with. The new rota system; police station visits in the middle of the night; making decisions in matters of Mental Health Act and its complicated sectioning procedures; chairing ward rounds, team meetings and handling new projects etc.

There are yet other challenges on the academic and teaching side. After qualifying the Royal College examination, the schedule for reading is completely changed and there is no structure to follow for academics. We need to keep pace with the recent advances in our chosen specialty which keeps developing so fast that it often becomes hard to read without having any structure or schedule. There will also be a pressure to take a research project but it may need a lot of effort and time to finish it off within a period of

three years. It is rightly advised by the seniors to start any project early so that it could be finished off in time.

In spite of all these challenges there is that sense of achievement of something, which was dreamt. On the lighter side the on calls would become slightly easier as compared to the life of junior doctors and being non-resident is the biggest advantage. There is also a feeling of being trusted by other people, taking decisions and making plans which boosts the confidence.

'In spite of all these challenges there is that sense of achievement...'

When a position is given it always brings more responsibility and accountability. When decisions are made, they are our own decisions and we are responsible and accountable if things don't go right (I mean we would make decisions with the help of other team members but still we have the final say). In difficult situations it is always better to seek senior advice

and in the absence of the seniors, colleagues can give good advice as well.

These are some tips that were helpful when I started the job:

- a. A good Supervisor will make life much easier.
- b. You will look forward to going to your job if you have an efficient secretary.
- c. Team members can make the job very easy or very hard – it depends on their and your expectations.
- d. Peer group forms an important place to talk to others who are in similar situation.
- e. Too many things on hand can be challenging. It is good to have few and finish them off in time.
- f. If research is in your mind then the work should be started well ahead of the time. It is advisable to even start working on the project before the job starts.

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Innovations in Medical Education**The use of a film teaching resource for medical students**

Dr Erin Turner, Locum Consultant Psychiatrist
Early Intervention Service, Solihull

During my time as specialist registrar I had the privilege of working as an Honorary Clinical Lecturer. One of my roles was to develop a teaching resource for medical students to be used as an adjunct to their lectures and clinical placement.

I interviewed medical students who had completed their psychiatry placement and asked them about their experience and about which psychiatric topics they felt least confident.

Many of them felt disorientated at the start of their placement and were unsure about the differing roles of the various members of the mental health team. They also felt under confident about the use of the mental health act and about when a GP should refer to a psychiatrist.

Many students, particularly those on an older adult placement, felt frustrated that they had had limited experience in dealing with psychotic illness.

With these comments in mind, I decided to produce a film about a young man who experiences a first episode psychosis. The film follows his journey from home through primary and secondary care, including admission under the mental health act. It finishes with his recovery and return home, dispelling the myth that people with mental illness never recover. Throughout the film the students are introduced to the various members of the mental health team and their roles explained.

In order to enhance the learning experience I combined the film with interactive activities for the students to complete. I worked with Birmingham Medical School's education and technology department, to develop the script for the film and design the web activities.

Actors played the part of the young man (Patrick) and his mother, and I managed to twist the arms of some colleagues to play the parts of the mental health team members! Ward 21 at Solihull hospital kindly agreed to let us film there.

We then edited the film into 7 sections, each lasting 3-5 minutes. The themes of the films are:-

1. **Patrick is becoming unwell.** His mum talks directly to the camera explaining his behaviour, and her concerns. She finishes by

Case Studies in Psychiatry

Introduction Mother & Son Patrick & the GP Patrick at home Approved Social Worker MHA Assessment Patient Admitted Psychiatrist Treatment Patient Discharge Patrick's Mother

Meet the Mother & Son

1

2

3

4

5

submit

Profiles:

Mother

Patrick's mum, Hilary is 41. She works as a school secretary. She is divorced and has 2 children-Patrick, and his older brother.

Son

Patrick is currently at 6th form college. He past medical history is unremarkable. His interests include music, going out with his mates, and he supports Aston Villa.

Action: Watch the video and answer the following question.
From the moms account, what problems is Patrick experiencing? List 5 possibilities in the boxes above.

Previous Next

saying she is going to make an appointment with the GP.

2. **Patrick visits his GP**, and manages to convince him that he is just "stressed". The GP doesn't ask very searching questions, but arranges to see him again in 2 weeks.

3. **Patrick fails to keep this appointment.** His mental state continues to deteriorate. He is now floridly psychotic and displaying paranoid behaviour at home. The film clip ends with the mum in distress talking to the GP on the phone, who reassures her that he will arrange a mental health act assessment.

4. **The AMHP phones** Patrick's mum to coordinate the assessment.
5. **The MHA assessment takes place** at Patrick's home with his GP, the AMHP and the Psychiatrist in attendance. He is placed on a section 2 of the MHA.
6. **Patrick is admitted** to the psychiatric hospital. The nurse completes the admission documents, explains ward policy and takes Patrick to his bedroom.
7. **A mental state examination is carried out** by Patrick's psychiatrist, eliciting positive psychopathology.
8. **Four weeks later** Patrick has made a good recovery and is ready for discharge home. The various members of the team are present, including the home treatment team and the CPN.
9. **Patrick is back home.** His mum again talks to camera giving an update on his progress and her ongoing concerns about relapse.

After each film the students have to complete a web based activity before they can move on to the next film.

These include multiple choice questions on the aetiology, diagnosis, treatment and prognosis of psychosis. They are also asked to match the different types of MHA Section with the correct definition, and then they have the opportunity to complete a section 2 paper.

Case Studies in Psychiatry

Introduction | Mother & Son | Patrick & the GP | Patrick at home | **Approved Social Worker** | MHA Assessment | Patient Admitted | Psychiatrist | Treatment | Patient Discharge | Patrick's Mother

Approved Social Worker

There are a number of different sections of the 1983 Mental Health Act these are the ones most commonly used. Match the following sections with the correct definitions

Section 2 Section 3 Section 4 Section 5(2) Section 5(4)

Detention in hospital for treatment, for a period of up to 6 months

Admission to hospital for assessment for a period up to 28 days

Detention of voluntary patient in hospital by a nurse for a period of up to 6 hours

Used for detention of voluntary patients already in hospital for a period up to 72 hours

Emergency admission to hospital, only requiring one medical

Previous Next

correct definition, which, if done correctly, is illustrated by the relevant part from the film on mental state examination.

Once the case study is completed, students should be able to:

1. Better understand the mental health act
2. Consider the effect deprivation of liberty can have on our patients
3. Better elicit psychotic psychopathology through the mental state examination.
4. Improve their knowledge of the biological, psychological and social aetiology and management of psychosis
5. Understand the roles of the various members of the mental health team
6. Have a better understanding of the social aspect of mental illness

Case Studies in Psychiatry

Introduction | Mother & Son | Patrick & the GP | Patrick at home | Approved Social Worker | MHA Assessment | Patient Admitted | Psychiatrist | Treatment | Patient Discharge | Patrick's Mother

Patrick is Discharged

5 weeks have passed since Patrick was admitted acutely unwell. His mental state has improved, and he has just returned from a successful week of home leave. The team agree that Patrick is ready to be discharged from hospital and have arranged a meeting with the relevant members of the team involved in Patrick's care.

Profiles:

Psychiatric nurse

Fitz Jones, Psychiatric nurse working with home treatment team, who often visit people if they are on hospital leave, or if they require more intensive psychiatric input at home.

Bernie Macmillan-Community Psychiatric nurse, Patrick's care coordinator. She is the first person Patrick or his mum will contact if there is a problem. She will arrange to meet Patrick initially every week, offer him support and ensure he attends his outpatient appointments.

Streaming: 0:00:17.038

Action: Watch the video of the discharge meeting and then click the next button to continue.

Previous Next

The case study is on the Birmingham medical school website (medweb4) and can be accessed by anyone from most computers. They are informed about it during their introductory lecture at the start of their psychiatry placement. They can complete it at home or at work and we have encouraged them to discuss it during their tutorials.

This teaching resource was completed in September 2008 and students feedback has been extremely positive. I am currently working on a new case study looking at two very different overdose attempts (one impulsive, the other premeditated) and how the risk assessment in A and E should be carried out. If you would like to access the site for your own teaching purposes, the website is:

They are asked to consider the effect that detention can have on the psyche of our patients which then links to a site where patients discuss their personal experiences. The activity on psychopathology asks them to link the terminology with the

medweb4.bham.ac.uk/psychiatrycal



Audit **'Gold Discharge Summaries' in acute adult wards at Shelton Hospital, Shrewsbury - a completed audit cycle** by Dr Muhammad Mushtaq (ST3)

Introduction and background of Gold Discharge Summary

- Following discharge of a patient from the wards, immediate handover to primary care services is very important to ensure continuity of care.
- For this purpose at Shelton Hospital, we use "Gold Discharge Summary" which is a gold/yellow coloured single page document with 3 carbon copies. This contains all necessary information needed by the GP to ensure continuity of care in Primary Care soon after patients discharge while a formal discharge is being prepared.
- This document is filled by the team junior doctor and is required to be faxed and/or posted to GP within 24 hours of discharge of patient from the ward.
- One copy is sent to pharmacy, one kept in patient notes and one given to patient.

Gold Discharge Summary contains 32 pieces of information such as: patient name, date of birth, gender, unit no, NHS no, Consultant & GP names, dates of admission and discharge, whether discharged against medical advice, legal status and ward on admission and discharge, after care status, key worker allocated, diagnosis and ICD 10 code, treatment plan and follow up arrangements, drug dose, duration, directions, period of supply, any specific problems identified and finally signature and date.

- It is an absolute necessity that this Gold Discharge Summary is filled in completely as much as possible as any information missing from this summary can have impact on quality and the continuity of patient care following discharge.

Objectives

Purpose of this re-audit was to review if Gold Discharge Summaries are filled in completely and to compare findings with a previously done

audit, 18 months ago in Sep 2007, for any evidence of improvement in standards.

Recommendations following previous audit (September 2007):

- Importance of findings of this audit be emphasised at induction to junior doctors
- To ensure that GDS are filled in by the team junior doctor who can fill it more completely, except for out of hour discharges (DAMA) when covering/ duty doctor will fill them.
- To maintain legibility of documentation, do not lean on Gold discharge Summary as having attached carbon copies, any pressure gets imprinted on underlying pages.

Standards

- 100% documentation is expected for all 32 criteria.

Methodology

- Carbon-copies of all discharge summaries filled during month of April 2009 were obtained from the hospital pharmacy
- 30 GDS were selected at random from about 75 available in total (in line with previous audit protocol)
- Documentation in all sections of GDS was reviewed and data was extracted retrospectively
- Data was analysed manually to obtain results
- Compared results with previous audit in September 2007 to draw conclusions
- Out of 32 sections in GDS, 20 criterions were available for comparison from previous audit. That has been depicted in graphs/ charts below in Figures 1 & 2.

Comparison of results

- **Good News:** Standards improved in 8 sections since previous audit, namely name of GP, name of consultant, ward on admission, after-care status, treatment plan, key worker, date of next review and whether patient was suitable for 28 days dispensing at a time.
- **Not So Good:** Performance worsened in documentation of 6 sections, namely gender,

diagnosis, ICD 10 Code, any specific problems, date on admission and ward on discharge.

Summary of the current audit (April 2009)

We continued to maintain high standards of the previous audit on criteria 1-10 as in Figure 1, where achievement has been 90-100% throughout.

Least recorded sections (less than 50% documentation)

- ICD 10 diagnosis (10%)
- Specific problems (13%)
- Next review date (37%)
- 28/7 medication (43%)
- Adverse drug reactions (23%)

Conclusions

- With mixed results, there is “overall improvement” in achieving standards, but still some entries that give most valuable information are significantly being missed out.
- This trend was seen most likely to happen when the prescriptions were done by a doctor not belonging to the team.
- Legibility of handwritten documentation was seen in

100 % of cases.

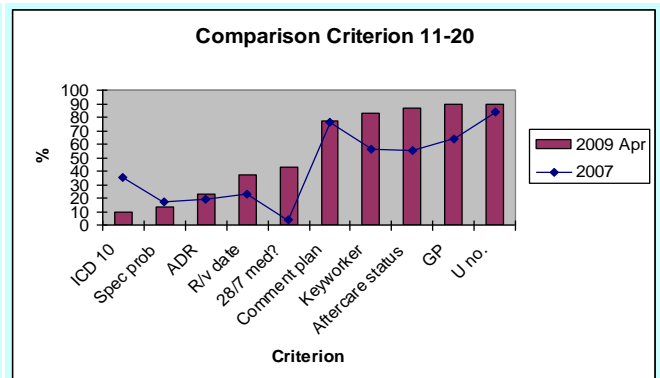
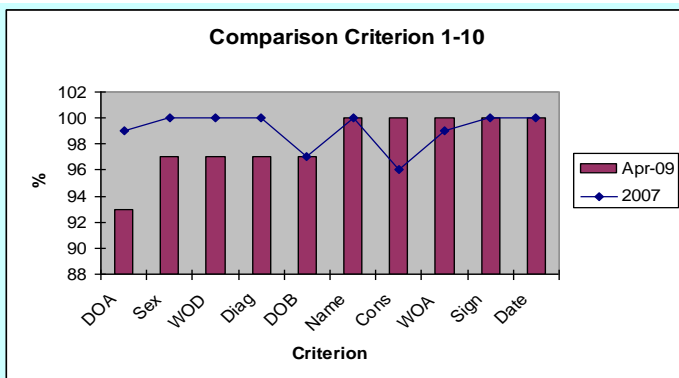
- Robust action plan is needed to maintain and improve our documentation standards further.

Recommendations

- Importance of findings of this audit be emphasised at induction to junior doctors with more emphasis on areas lacking in high standards.
- Efforts need doing to ensure that GDS are filled in by the team doctor. Sometimes, GDS could be done partially in advance of planned discharge as is being practiced in New House addiction unit at Shelton Hospital.
- If duty doctor is involved filling in GDS, they should discuss patient with nursing staff or some one from the team and check notes for all necessary information as much as possible.
- Again to maintain legibility of documentation, do not lean on Gold discharge Summary while writing on them.

Audit Action Plan

- Implement above said recommendations and re-audit in 1 year time.



Correspondence



Feedback from last issue

✉ I have received positive feedback about the Mind the Gap newsletters you produce. One consultant has suggested that you include a page for other specialties where the Chair of each SpR/ST4-6 peer group can provide a paragraph to update on what is happening in their specialty within the Division. Is this something you would consider for the next edition?

Nikki Davies

RCPsych West Midlands and Trent Divisions Manager

(Eds. We would be delighted to include such updates. We look forward to hearing from the peer group Chairs)

✉ Well done. Good colourful presentation. Keep up the good work.

Dr Mahmoud Saeed, Consultant Old Age Solihull

✉ This is very impressive!

Bill Calthorpe

Peer group reps

Chairperson	Abhinav Rastogi
Vice Chair	Panthratan Grewal
Secretary	Emma Lambert
Regional representatives	
North B'ham	Abbas Lohawala
South B'ham & Solihull	Pallavi Rajput
Coventry, Warwick, Worcs, Hereford	Rupinder Kaler
Staffs and Shropshire	Jay Makala
Black Country	-

Pearls of Wisdom

Invaluable advice to trainees from senior clinicians

Professor Swaran P Singh

*Professor of Social & Community Psychiatry, University of Warwick
Consultant in Early Intervention Psychiatry, Birmingham*

- ◆ **Every clinical encounter is also a therapeutic one.** Never lose an opportunity to instill hope and engender optimism in your patients.
- ◆ **Avoid dogma and dogmatism.** It is when you feel absolutely certain that you need to question your assumptions.
- ◆ In our profession, **one is never too old or too experienced** to learn, to admit mistakes or to seek advice.
- ◆ **Never write anything in notes, letters or emails that you might regret later.** So never dictate letters when in a bad mood. And remember that everything you write must stand outside scrutiny.
- ◆ **Don't fight change standing in the sidelines.** Change is constant. You cannot stop it but you can influence it by participating.



DIARY

Peer group meetings

13 July 2010

14 September 2010

9 November 2010

RCPsych

• **21-24 June 2010**

College Annual Meeting:
'Advancing Science' @ Edinburgh

• **14-15 October 2010**

Faculty of General & Community Psychiatry. Annual Conference 'Dawn of a New Horizon' @ London

• **Friday, 10 December 2010**

West Midlands Division Winter Meeting @ Venue TBC

BMI

• **Tuesday 8th June 2010**

'Organisation management of traumatic stress'
Prof. Neil Greenberg (London)

Annual Conference

: Organised by GA Higher trainees:
: Open to all specialties and grades:

Prof. Swaran Singh

Working for the NHS in a cold economic climate

Peter Hughes (London)

Blogging from Haiti: A Psychiatrist on the front line

Debate

Workshops

....and much more to be confirmed

Friday, September 10th 2010

Uffculme Centre, Queensbridge Road,
Birmingham, B13 8QY

Further info:

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This newsletter is intended to inform and promote the positive work of the West Midlands General Adult Psychiatry Higher trainees. It is also hoped that it provides a platform for junior trainees, trainees in other specialties and Consultants. We aim to publish this newsletter quarterly. Portfolio certificates are provided.

Contributions should be sent to the editors ✉ rehan_007@hotmail.com ✉ amandurrani@gmail.com