Mind the Gap

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

Editors : Dr Rehan Siddiquee & Dr Aman Durrani

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Welcome !

Dear colleagues,

It gives me great pleasure to bring to you the inaugural issue of Vol. 2 of “Mind the Gap.” I take this opportunity to thank Dr. Durrani for all the help and creative input in making this issue.

I hope that we are able to push the brand of this newsletter not as an exclusive but as an inclusive platform not only for the Higher Specialist Trainees, but for all grades in General Adult Psychiatry in the West Midlands.

We have a very eclectic mix of articles in this issue which we hope you will find both interesting and informative.

I would be grateful if you could send us feedback and share your opinions of this issue with us.

Dr. Rehan Siddiquee

Editorial: ‘*The American way*’

Dr Rehan Siddiquee
Chair of General Adult Psychiatry SpR/ST4-6 peer group

I was fortunate to be able to attend both the main annual meetings held by the American Psychiatric Association in 2008. The showcase event was the Annual Meeting held in Washington D.C. in May and the Institute on Psychiatric Services in Chicago in October.

I came across some very innovative teaching methods, unusual sessions and networking practices in both these meetings.

For starters, the most surprising thing I came across was the cost. Early registration for trainees is a meagre $100 compared to the $800 regular fee! Even with travel costs, the meetings seem to be more attractive financially than any other meetings/conferences I have attended.

At the annual meeting the ‘Focus Live!’ sessions involved a roomful of people with wireless handsets choosing one of four answers to questions asked on the screen exactly like the audience poll on “who wants to be a millionaire.” It ensured the entire group was involved and awake throughout the sessions. Trainee led sessions were very popular with the trainees as they would be able to interact and learn from peers. The absence of senior psychiatrists made these sessions informal, spontaneous and interactive.

We are all aware of the excellent networking opportunities that these meetings provide, but to make it even better, there was a lunch meeting organised for trainees called ‘Meet the experts.’ Several tables for around ten with a placard were scattered around. The placards had the names of specialties like “General & Community”, “Addiction” and “Liaison” on them. The tables had two senior psychiatrists each and trainees could choose which table to sit at and chat with the experts. They could even choose to have starters at one table, the main course another and dessert at yet another.

The most innovative practice to ensure attendance I have ever seen was a raffle held on all days at the end of each session (morning and afternoon). All registrants were given tickets that they had to enter into the draw at the end of each session. The prizes included a digital camcorder, PDA, $100 cash, and other such desirables.

Although, some of these methods might not be to everyone’s taste this side of the pond, I think it is definitely worthwhile attending atleast one APA meeting in your trainee years.

Staying in touch with Dr Pavan Chahl

Mental health news in the national and international media

The Buzz

Stigma in the military

The Pentagon has ruled this month that soldiers who have Post-traumatic stress disorder (PTSD) should not be eligible to receive a Purple Heart-a medal for gallantry-unless they have a physical wound as well. The implication is that its counts for nothing if you have a mental illness secondary to fighting for your country, if you don't bleed you are "a faker". This is clearly a harsh stance considering that 20% of war veterans suffer from mental illness and a high number commit suicide.

The Nation

Suicide rates in the U.S army

Staying with the topic of mental health and the military the steadily increasing suicide rates in the U.S army reached an all time high in 2008. 128 soldiers committed suicide in 2008, this for the first time since the Vietnam war is a rate higher than the civilian population. The increase rates have been a direct result of the U.S military being involved in high intensity conflicts in Iraq and Afghanistan.

Newsweek

Waltz with Bashir

An animated film by Ari Folman looks at the psychic cost of war. It is a beautiful film that borders on being a hallucinatory experience with its stunning graphics. It focuses on the 1982 Israeli-Lebanon war and the repressed memories of an ex-Israeli soldier. The film is an attempt at making sense of what happened during that conflict. The director has used animation since it "functions on the border between reality and the sub-conscious". A must see film for any one interested in Psychiatry.

Rolling stone

Obama likes a drink

Even though these are sobering times "it doesn't require everyone to be sober". This article talks about the more relaxed attitude of Barack Obama to drinking compared to George W. Bush and how this "connects him with a rich presidential tradition". It focuses on the issue of moderation in all things and away from the extremes of alcoholism and strict abstinence.

Slate.com

Invitation from BMI President

Dear Trainees, I would like to invite you to take advantage of this opportunity to see some very eminent and accomplished speakers. The Birmingham Medical Institute (Section of Psychiatry) is arranging a series of lectures for 2009 exploring the interface between neurology and psychiatry. The first lecture will be:-

The Neural Correlates of Psychosis

Dr Sukhwinder S Shergill
Reader in Psychiatry and Head of Cognition, Schizophrenia and Imaging (CSI) Laboratory, Institute of Psychiatry, King's College, London

Tuesday 3rd March at 7.30 pm- 8.30pm
Birmingham Medical Institute, 36 Harborne Road, Edgbaston, B15 3AF.

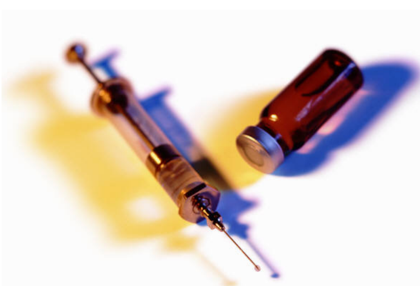
Profile: Dr Shergill is a prolific young researcher. His research as head of the CSI Laboratory at the IoP examines the mechanisms underlying the development of psychotic symptoms in schizophrenia, using psychophysics, functional neuroimaging and therapeutics. He has conducted ground-breaking research on the neural mechanisms of auditory hallucinations and has even found time to explore the neurological basis of force escalation in tit-for-tat situations providing an explanation for playground confrontations escalating into fights. He is also an associate editor of the British Journal of Psychiatry

All BSMHFT trainees are welcome to attend. Please contact Elaine Simpson email: bmibham@aol.com for further information

Best wishes,**Dr Manny Bagary**
Consultant Neuropsychiatrist, President Section of Psychiatry, Birmingham Medical Institute

Course review by Dr John Roche

MSc in Treatment of Substance Misuse, University of Birmingham



I am one of about 20 students who started this new course in Autumn 2008. This first academic year has consisted of lectures on a Wednesday afternoon at the Centre of Excellence in Interdisciplinary Mental Health on the University of Birmingham campus. There are three doctors on the course, and other students include midwives, nurses and drug workers.

It is fairly unique in its clinical focus, with the structure of the modules linked to a conceptual model of treatment. This helps to understand how the various treatment strategies might fit together.

The format is one afternoon of lectures each week for the first two years, with the final year dedicated to producing a research project and dissertation.

The three modules in the first year are (1) Introduction to Substance Misuse, (2) Assessment, Case Management and Harm Reduction, and (3) Building Motivation for Treatment. In the second year there is (4) Research Methods, (5) Changing Addictive Behaviours, and (6) Rehabilitation and Aftercare.

It is a three year part time taught masters, although it is possible to complete a postgraduate certificate after one year, or a diploma after two years. It is also possible to take individual modules as CPD – e.g. one could take the Research Methods module as a standalone in Autumn term 2009, and the introductory module would also work well as it contains a little bit of everything.

The course is clearly beneficial to those with an interest in a career in Addiction Psychiatry. The workload is fair with plenty of background reading, though this is all easily accessible through the University's IT system. A 4000 word assignment is required at the end of each term. There are regular tutorials and students are well supported.

So far I have found it excellent, with knowledgeable speakers and interesting topics. The enthusiasm of the staff rubs off on the students and attendance and interest levels are high. It is extremely well organised, despite being in its first year, and this will no doubt be maintained for subsequent intake years.

I now have an NUS extra card and am enjoying cheap cinema and discounts at high street shops – essential in these difficult financial times!

It currently costs £1450 per year and £500 is reclaimable from the study leave allowance. I also now have an NUS extra card and am enjoying cheap cinema and discounts at high street shops – essential in these difficult financial times!

Further information is available from www.medicine.bham.ac.uk/treatment and I would be happy to discuss the course further with anyone interested.

Dr John Roche, ST4 in General Adult Psychiatry, Kidderminster Hospital (Email: drjjroche@gmail.com)

Peer group reps

Role	Name
Chairperson	Rehan Siddiquee
Vice Chair	Arif Rahman
Secretary	Sadira Teeluckhdary
Regional representatives	
North Birmingham	Amitav Narula
South B'ham & Solihull	Sara Adshead & Helen Campbell
Coventry, Warwick, Worcs, Hereford	Suraj Singh
Staffs and Shropshire	Catherine Thompson (until April)
Black Country	Panthrathan Grewal

Reflections on reflecting! Setting up a reflective practice group for emergency psychiatry

Dr Catherine Thompson. SpR in Liaison Psychiatry,
North Staffordshire Combined Healthcare Trust (cathmjthompson@hotmail.com)

Reflective practices now form an important part of our training and the Royal College of Psychiatrists suggests that trainees make such reflections through their training portfolios and supervision sessions with their educational supervisors. Whilst supervision with educational supervisors and work place based assessment tools provide a forum for reflection on our day to day practices, emergency assessment and on call practices can fall prey to neglect in this area. A local survey of trainees found that none of them had produced reflective accounts for on call assessments and work place based assessments were not being undertaken for such assessments. Supervision with educational supervisors can provide a forum for discussing on call assessments but there was wide variation of content amongst trainees' supervision sessions with many feeling that this was not an appropriate forum to discuss on call assessments. A multidisciplinary training day held in April 2008 for all those working within emergency psychiatry revealed ongoing communication difficulties between teams and disciplines , for example between the Crisis Resolution team and junior doctors on call. It was felt that there was a lack of understanding of roles between teams and between grades of seniority within the medical on call rota.

It was agreed that in my capacity as Liaison psychiatry SpR I would attempt to improve understanding and communication on a multidisciplinary level between those teams involved in emergency assessments. This need was combined with the need for trainees to reflect on all aspects of their working practices and the idea of a regular group which reflected on practices within emergency psychiatry was born . The aim of the group was to provide a regular forum for trainees to reflect on their on call assessments, improve multi disciplinary working relations through understanding of roles and provide a forum for staff to follow up outcomes of on call assessments. As with all reflection there was an overall goal of learning what might be done differently should the scenario arise again. I was clear that the group did not have a primary aim of providing clinical supervision to trainees or other disciplines.

Once the aims of the group were decided on I approached relevant team leaders, the college tutor for CT1-3 trainees and the trainees themselves – all were keen for such a group to be set up. Perhaps the most difficult aspect logistically of setting up the group was finding a time that suited everyone involved, I was keen that the group became regular fixture in peoples minds and that it was perceived as a voluntary and informal discussion forum. It was agreed that the group would meet on the first Thursday of every month for one hour - flyers were sent to all trainees, the Crisis Resolution team, the liaison psychiatry team and nurse practitioners (who fulfil a role similar to the junior doctors on call from 9 – 5 pm). Setting up the group came with teething problems – trainees currently rotate every four months and this only gives a short window of opportunity for the group to become a regular fixture in peoples' minds. The first two attempts at the group were met with no attendees – but persistent reminders paid off and the group now has attendees of around ten people at monthly meetings.

Right from the outset it was clear that trainees really felt a need for an outlet for their on call frustrations

I had concerns with regard the group process and dynamics - worrying that people would be reluctant to talk and feel resentful at yet another commitment –how wrong I was! Right from the outset it was clear that trainees really felt a need for an outlet for their on call frustrations. Cases have been varied and the presence of members of the Crisis Resolution team and Liaison nursing team has been invaluable in linking up roles in emergency assessments. Trainees have commented that the group has allowed them to complete the reflective practices part of their portfolio with ease and true understanding of the benefits of reflection. One further useful outcome is the provision

for follow up information regarding cases that we are able as a group to provide, thus enabling us all to see the bigger picture of the process in emergency assessments. My role as facilitator has been minimal as the group largely facilitates its self, although I do attempt to summarise key points from cases raised and encourage the group to reflect on how things could have been done differently and what steps can be taken to ensure this happens in the future. It is fundamental to the group that members feel they are able to speak openly without recourse, however, on occasion there have been issues which need to be addressed outside of the confines of the group and we have been able to decide as group when this should occur and through which process.

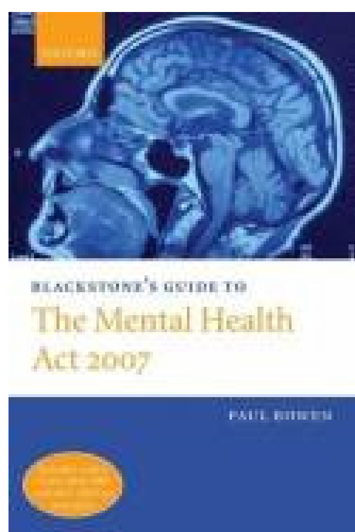
I think it is more valuable for those involved on the front line of assessment to be able to air their views freely without the pressure that the presence of a consultant body may add.

Overall the group has, I feel, been successful in achieving its aims but there are issues which still need to be addressed. Presently the group does not have any members from the consultant body and as such their role in on call situations cannot be fully understood, nor communication between the junior and senior medical on call rota improved. However, I do have concerns that the dynamics of the group would change substantially if consultants were also invited and currently I think it is more valuable for those involved on the front line of assessment to be able to air their views freely without the pressure that the presence of a consultant body may add. I plan to address this quandary with the group at our next meeting. GPVTS and F2 trainees who are also included on the on call rota have been difficult to recruit to the group and I aim to continue encouraging them that the aims of the group are valuable to all involved in emergency assessments and not just those already progressing to a career in psychiatry. I am also a trainee and as such the future of the group remains uncertain when I leave this post, anyone willing to continue facilitating the group needs to recognise the commitment to time and energy in recruiting members needed and relies, I suspect, on a willing higher specialist trainee taking up the gauntlet. I very much hope that the group is able to continue and would encourage higher specialist trainees working in other trusts to consider setting up such a group; it provides a unique opportunity for multi disciplinary communication and reflection and confirms that simple communication can improve understanding and ultimately patient care.

Book Review by Dr Sanjay Khurmi

Bowen P. (2007) Blackstone's guide to the Mental Health Act 2007. Oxford University Press Ltd. RRP £ 39.99

The title of this book is slightly misleading. This book primarily focuses on the amendments made by the Act of 2007 on both the Mental Health Act of 1983 and the Mental Capacity Act 2005. It is not a comprehensive guide to Mental Health Act 1983 and therefore it is not intended to be in competition with the Mental Health Act Manual by Richard Jones, but attempts to complement it. Indeed, this book is more focussed on the implications of the amendments, legally, in practise, and on human rights, the latter being a specialist field of the author. The author, Paul Bowen, is a barrister who specialises in mental health law. He has represented clients in highly influential mental health law cases including "Bournewood". The book itself is divided into two major parts focussing on the implications on both acts and includes copies of the three acts in the appendix. The author introduces each amendment by discussing the historical development of the law in the area in question, discusses the reasons why the amendments were deemed to be required, legally describes the amendments and then discusses the potential implications of the change. Despite the subject matter being difficult and complex, this approach enabled me to gain insight and understanding of the changes. The author writes in a lucid readable manner and illustrates the Act using relevant case law and discussions in parliament. Overall this book is well written and explains complex issues in a thoroughly understandable manner. This book would be of great interest for all those wishing to gain a greater understanding of the Mental Health Act 2007.



Case report: Antipsychotic Induced Hyper-Prolactinaemia and the Risk of Breast Cancer

by Dr Rinky Ray (CT3) and Dr Rehan Siddiquee (SpR)

Background

The incidence of breast cancer in patients with antipsychotic induced hyperprolactinemia has been explored by a handful of researchers. The most significant of these studies are the Haddad PM et al,2000, Wang PS et al, 2002, and Halbreich et al, 1996.

Introduction

This 38 year old lady was transferred to a psychiatric in-patient unit with a diagnosis of Paranoid Schizophrenia (F20.0). She has been under the care of local psychiatric services for nine years and over the course of her involvement with mental health services had been diagnosed with recurrent depressive disorder with psychotic episodes, schizoaffective disorder and psychopathic personality traits at various stages of her illness.

'the breast enlargement secondary to hyper-prolactinaemia had started to adversely affect her mental state'

Prior to her current in-patient admission she had been treated with oral amisulpiride, quetiapine and clopixol. None of these medications could be administered at the maximum therapeutic doses or for a prolonged duration of time as she was noted to develop symptomatic hyperprolactinemia and secondary breast enlargement. After her transfer to the current unit she was treated with olanzapine and as it was unsuccessful in resolving her psychotic symptoms she was commenced on clozapine. Due to her increased sensitivity to antipsychotics she was maintained at a dose of 75 mg twice a day. This dose was sufficient to control her psychotic symptoms effectively.

However, the breast enlargement secondary to hyperprolactinaemia had started to adversely affect her mental state. Therefore, in 2006 she was referred to a local surgical unit for assessment regarding suitability for a breast reduction surgery. She underwent the breast reduction surgery in July 2007.

A histopathological examination of the excised breast tissue revealed precancerous cells. This was later diagnosed as Non-invasive Ductal Carcinoma. The patient did not have any pre-existing lumps in the breast and does not have a family history of breast cancer. She now has regular surgical follow-up and yearly mammograms for the past two years which have all been normal.

From a psychiatric point of view she has shown significant improvement in her mental state on the current dose of clozapine and is ready to be discharged from in-patient care to supported accommodation as part of a community rehabilitative placement.

Conclusion

This case highlights one of the possible and potentially lethal consequences of anti-psychotic induced hyper-prolactinaemia.

Clinicians commencing patients on anti-psychotics must be aware of the potential link between anti-psychotic induced hyper-prolactinaemia and breast cancer.

This also has implications on the information provided to service users when initiating antipsychotics and guidelines published regarding monitoring patients on neuroleptic medications.

It also raises an important question for more research to be undertaken around the association between anti-psychotic induced hyper-prolactinemia and breast cancer.

References

1. Haddad PM et al,Antipsychotic induced hyperprolactinemia, mechanisms, clinical features and management, Drugs 2004; 64:2291 – 304.

2. Halbreich U et al, Are chronic psychiatric patients at increased risk of developing Breast Cancer? Am J Psychiatry1996; 153: 559-60

3. Wang PS et al. Dopamine antagonists and the development of breast cancer. Arch Gen Psychiatry 2002; 59: 1147-54.

Obituary: A Tribute to Dr Sheikh

by Dr Sara Adshead (SpR)

Dr Sheikh sadly passed away on 21st July 2008 after fighting a long and courageous battle against cancer.

He was a well known figure in the West Midlands, having been Consultant Psychiatrist at Solihull Hospital for 17 years.

Dr Sheikh graduated from university in Karachi in 1979. He moved to England in 1982, where he embarked on a 26 year career in Psychiatry.

After completing a Diploma in Psychiatry in 1986, and achieving MRCPsych in 1987, he was appointed Consultant Psychiatrist in 1991, and made Medical Director in 2000.

His extensive knowledge, considerable professional expertise and generosity of spirit meant he was a very popular & highly respected trainer.

Over recent years, his professional commitments have included Clinical Advisor for the Healthcare Commission, Second Opinion Doctor for the Mental Health Act Commission, Medical Member of Mental Health Review Tribunal, Psychiatric Member on the Parole Board, Honorary Senior Clinical Lecturer, Psychiatric Member of the Multi-Centre Research Ethics Committee, and Membership Examiner for the Royal College of Psychiatrists.

In his role as Educational Supervisor, Dr Sheikh provided guidance and motivation to a great number of Psychiatric trainees over the years, including myself. His extensive knowledge, considerable professional expertise and generosity of spirit meant he was a very popular and highly respected trainer.

My personal memories of Dr Sheikh are of his true passion for the subject of Psychiatry, and his genuine compassion towards his patients and fellow colleagues.

He was always approachable, ready to listen, and constantly available to provide support and guidance.

He had a boundless enthusiasm, with a determination to live and enjoy life to the full. He was an avid reader of literature (many of us will be familiar with Dr Sheikh's regular reading lists of recommended books), a frequent theatre-goer, and a Mercedes enthusiast.

He loved sports, particularly cricket, and often put many a colleague to shame with his apparent limitless energy and active sportsmanship.

He also enjoyed debate and would regularly stimulate active discussion, with a genuine interest in learning about others' opinions and values.

However, above all, he was a proud family man, and spoke frequently of his wife and two daughters.

Dr Sheikh was extremely popular amongst his colleagues and patients alike (his office at the Newington Centre displayed paintings and pictures created for him by several of his patients).

I personally was very fortunate to have worked with Dr Sheikh as his junior trainee in 2001, and he remained my mentor from then onwards.

I will be eternally grateful to him for his generosity of spirit, persistent willingness to give up his time amongst numerous professional commitments, and his genuine concern for my personal welfare – a sentiment which is also shared my many of my peers.

Dr Sheikh fought a long battle against a devastating illness. Yet he retained dignity and an astounding degree of fortitude throughout.

In spite of being in the midst of chemotherapy, he briefly came back to work towards the latter end of 2007, resuming full time clinical responsibilities within weeks of his return, much to the awe of his colleagues.

This is a true testament to Dr Sheikh's strength of character, and dedication to both his work and his patients.

I have no doubt that I, like the multitude of others who have had the privilege of working with Dr Sheikh, will take inspiration from his integrity, dedication to his work, and his tremendous courage, even in the very darkest of hours.

My thoughts and best wishes are with Dr Sheikh's wife, Maria; and his two daughters Katrina and Anneka.

Pearls of Wisdom

Invaluable advice to trainees from senior clinicians

Dr Martin Deahl, Consultant Psychiatrist

- **If in doubt see the patient!**
- **He/she who knows the patient best should have the biggest say into the decision making**
- **Don't appease!** Medicine is about doing what's in the patient's best interest, not winning a popularity contest! Sometimes the right thing to do is not what the patient wants to hear.
- **The 2 minute test**...ask a colleague to look at a set of notes belonging to one of your patients....if they cant work out the problem, the management, the plan, the risks and the legal status within 2 minutes, something is very wrong with your note keeping
- **Better to have made a bad decision than no decision at all!...**Have a plan and a timeline, trust your judgment and stick to it!
- **Risk...gut feelings are important.** They may run counter to operational risk assessments but are usually correct!

DIARY

Peer group meetings
10th March
12th May
14th July
15th September
10th November

ST5 Teaching
2nd March 2009
11th May 2009
6th July 2009

RCPsych

Friday, 8 May 2009
West Midlands Division Spring Meeting @ Village Hotel, Dudley

2-5 June 2009
College Annual Meeting @ Liverpool

BMI
3rd March
The neural correlates of psychosis
Sukhie Shergill

31st March
Conversational Analysis and unexplained neurological symptoms
Marcus Reuber

5th May
Linking risk and aetiology in sex offender evaluation and research
Anthony Beech

2nd June
Brain-body interactions and their relevance to psychiatry
Hugo Critchley

8th September
To sleep, perchance to offend: Forensic aspects of sleep
Jonathon Bird

6th October
Clinical leadership and medical (dis) engagement
Peter Spurgeon

3rd November
Annual Dinner (speaker TBC)

1st December
Cloake Medal

12th January 2010
Valedictory lecture
Dr Manny Bagary,
BMI President 2009-10

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**