

'Apparent questions' superficially appear to ask a question but, in fact, serve to signal to the audience the cleverness of the questioner. It is best to acknowledge this and then get on to answer the factual part of the question if necessary. 'Statements' need only a polite expression of gratitude for whatever point is being made. 'Question-statements' are the most difficult to respond to. They require a kind of free association to the material and a response to where the emphasis seems to lie in either the question or statement part. You may not get it right the first time, but the questioner can always use your response to clarify what he or she was trying to say. 'Woolly questions' can be dealt with in one of two ways – either used as a launching pad for any point you

forgot to include in your talk, or you can ask the questioner to formulate a concise question – most will be unable to do so. If you cannot answer a question say so and do not waffle. If appropriate you can offer to provide the information at a later date.

### Conclusion

Inevitably, these guidelines will not suit everyone. However, we thought it useful to record some of the advice, built up by trial and error, from the annual TAPS conferences. Although it is necessary to have material that will interest a particular audience, that alone is insufficient, and you need to carefully tailor the way it is put across.

*Psychiatric Bulletin* (1991), 15, 678–679

## Psychiatry of the elderly and geriatric medicine

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The West Midlands Senior Registrar Rotational Training Scheme in General and Geriatric Medicine has established links with the Senior Registrars in Psychiatry of the Elderly and their trainers. Reciprocal attachments to one another's specialty are encouraged and expected, much along the lines of the Royal College of Psychiatrists and British Geriatrics Society recommendations. This has been gratifyingly successful: the attachments have proved very satisfactory in themselves and have led to joint research and to friendships, some of which may form the basis of harmonious and constructive working relationships in years to come.

My postgraduate training had not included any formal psychiatric training and thus my knowledge was that of a forgetful undergraduate. Preparation for the month-long period of attachment began with textbooks but it was soon apparent that four weeks would not transform me into a psychogeriatrician.

I was to learn much about the differences between the practice of psychiatry of the elderly and medicine in the same age group. More importantly I was to learn their similarities. An extremely friendly reception soon put me at my ease and exemplified one notable feature of the attachment – the interest taken in the patient (or in this case, temporary staff member) as a whole person by all members of staff. This approach, coupled with the impression that there was always time to discuss problems or matters of mutual interest, allowed me to meet my objectives

and explore other areas. Geriatric services have developed partly as a result of cooperation with the multidisciplinary team, but I was delighted to meet a *de luxe* version of the same model in the psychiatric team. Likewise the finely tuned mechanism of community liaison and support was better developed than I had previously encountered. Particularly fascinating was the manner in which firm footholds had been established in the community, partly by the establishment and nurturing of reciprocal relationships with managers and owners of residential and nursing homes and others working in the statutory, voluntary and private sectors. Other features of interest include the different roles of and approach to members of nursing staff. The increased level of responsibility assumed by psychiatric nurses appears not to lead to any difficulties but rather brings out the best in many individuals. Perhaps the most relevant clinical point is the principle of seeking the correctable problems no matter how apparently hopeless the case. The importance of searching for problems or potential difficulties proved its value, both in terms of prevention and in building relationships with relatives and carers based on confidence. This proactive approach is to be recommended in geriatric medicine also, and indeed is familiar practice.

These attachments may be beneficial in other ways. The presence of a relatively senior geriatrician appears to be valued and I was glad to be able to advise on matters related to physical problems. This

was not without its educational value, for it emphasised for me the huge iceberg of physical pathology in this group of elderly mentally ill people and the adverse conditions under which clinicians caring for the elderly struggle. It was also possible to teach members of staff formally on topics related to physical care of the elderly, matters they encounter on a daily basis.

Many service problems in psychiatry of the elderly are similar to those which faced the earlier geriatricians. The services consisted of lonely clinicians waging a single-handed battle against resource deprivation and lack of colleague support. Most

geriatricians are no longer single-handed but the other factors have remained constant, and they are therefore in a position to understand and support their colleagues in psychiatry of the elderly. As senior registrars in the West Midlands burst forth from their cocoons into consultancy, they will graduate with a ready-made network of friends and colleagues in an allied branch of care of the elderly. Our scheme has great benefits and could be of value elsewhere. It might also be of value for more senior colleagues to experience similar attachments and one would hope that this sort of initiative could be supported by health authorities.

*Psychiatric Bulletin* (1991), 15, 679–680

## Trainees' forum

### A New Zealand experience

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Hamilton is New Zealand's fourth largest city. Situated on the banks of the Waikato river in the central North Island, it was my home during a year's experience as a psychiatric registrar in the Waikato Hospital. This paper describes aspects of a medical and psychiatric practice, including training in New Zealand, and offers general advice to trainees planning or considering overseas placements.

New Zealand has a population of three and a half million, divided approximately 2:1 between the North and South Islands. It has a multicultural population, with the majority being New Zealanders of European descent (known as *Pakeha*) and a sizeable minority of Maoris, the original inhabitants before the European colonisation in the 1800s. More recently a sizeable community of Pacific islanders has become established, especially in New Zealand's largest city, Auckland. There is a need for strong cultural awareness in all aspects of medical care, particularly psychiatry, where cultural beliefs and attitudes can readily be mistaken for symptoms or signs of mental disorder.

#### *Maori issues*

The Maori people have a strong sense of community, in fact the focus of traditional tribal life is the *Marae*, loosely translated as "village square". But it is more

than this, having important spiritual as well as communal meaning. This sense of community means that extended families are the norm, with children often raised by grandparents or other relatives. The shared spiritual beliefs of the Maori vary between different tribes but the following holds true in general. There is a sense of continuity with one's ancestors so that to hear their voices and have thoughts and actions influenced by them is accepted as normal, perhaps even a special gift. It is also accepted that misfortune or illness can result from transgressions of family members in generations gone by. Each tribe has a number of *tapus* which are prohibitions handed down through generations. The breaking of *tapus* may lead to *makutu*, the collective term for any conditions, medical or psychiatric, said to be imposed as punishment by Maori gods. The *Tohunga*, the "Maori doctor", can be consulted in these matters and will often prescribe traditional remedies. It was often my experience that Maori patients would have exhausted this avenue before turning to "*pakeha* medicine". It was therefore essential to consult with family members and Maori members of staff to help differentiate shared cultural beliefs from delusions and to discern the true nature of abnormal perceptions. This was of special importance in the differential diagnosis of psychotic disorders and schizophrenia.