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## Involuntary admission in Ireland

Putkonen & Völlm (*Psychiatric Bulletin*, March 2007, **31**, 101–103) are not entirely correct in their assertion that Ireland and Finland are alike in their non-requirement for non-medical authorities to be part of the decision-making process for involuntary admissions. Although in Ireland the initial process requires a medical practitioner to recommend an involuntary admission and a consultant psychiatrist to authorise it, the application is usually made by a non-medical person. Also since the Mental Health Act 2001 was fully implemented in November 2001 there is now a barrister-at-law, a layperson and a solicitor, as well as an additional two psychiatric consultants, involved in the review process which automatically follows each involuntary admission.

The new Act brought Ireland into line with its obligations under the European Convention on Human Rights and Fundamental Freedoms and with the European Convention on Human Rights Act 2003.

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## Reasons for entering staff grade posts

I was surprised that Fung *et al* (*Psychiatric Bulletin*, February 2007, **31**, 76) did not find non-availability of a National Training Number (NTN) to be a primary reason for entering staff grade and associate specialist grade (SAS) posts. I passed the MRCPsych part II in June 2006 following which there were no NTNs available locally. I was aware that a few candidates were applying before results came out and in retrospect I wish this is something I had pursued more actively. However, at that time I could not have known the intensity of competition for NTNs that would be precipitated by the approach of run-through training.

It was apparent that I would not secure a higher training post before the senior house officer rotation ended and therefore I applied for a staff grade post locally. Fung *et al* cite pay protection and additional clinical experience as the primary reasons for entering SAS posts. Although these are without doubt benefits of holding the post I did not see them as reason enough for postponement of higher training. I entered staff grade because I had no alternative.

My feeling from discussion with senior colleagues is that times have changed. Previously doctors would work as staff grades to accumulate additional clinical experience or for other reasons, and enter higher training when they felt ready to do so. With the introduction of Modernising Medical Careers (MMC) competition has become more intense and there is a general feeling that in future it will be much more difficult if not impossible to re-enter training from career grade posts.

Although I have been lucky enough to secure one of the last NTNs it required numerous applications, more than would have been allowed under MMC. I have certainly benefited from pay protection and additional clinical experience, however I could not cite these as reasons for entering the grade in the first place.

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## Teaching qualifications for psychiatrists

Dinniss *et al* (*Psychiatric Bulletin*, March 2007, **31**, 107–109) described their experience of the MSc in Clinical Education which they completed through the Peninsula Postgraduate Health Institute which is affiliated to the Universities of Exeter and Plymouth. My experience of pursuing a Postgraduate Certificate in Academic Practice (PGCAP) at King's Institute of Learning and Teaching (KILT) in London bears some similarities.

There is clearly an argument in favour of a formal training in postgraduate education or perhaps specifically clinical education. Specialist registrars/ST4 trainees might wish to enhance their skills and provide a better quality of teaching based on a strong theoretical background and practical experience.

The PGCAP has been a worthwhile experience, improving my teaching skills, knowledge of educational theory and facilitating reflective teaching practice. I have become more aware of issues relating to curriculum design and assessments. I believe this knowledge will be helpful for educational or clinical supervisory roles under Modernising Medical Careers.

Drawbacks of the PGCAP are that it is not discipline specific (although what has been learnt can easily be applied to all disciplines) and the course is expensive. To address the issue of discipline specificity, perhaps the College's Education and Training Centre might consider setting up a course aimed at psychiatric educators. Trusts could assist trainees with costs of courses through special budgets for medical education.

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I agree with Dinniss *et al* (*Psychiatric Bulletin*, March 2007, **31**, 107–109) that an MSc in Clinical Education is a worthwhile qualification, as there will be increasing pressure on senior clinicians to take an active part in teaching medical students and trainees. As society expects the healthcare system to be more and more transparent, clinicians will be held more accountable for their teaching and workplace-based assessments.

Learning to teach well means questioning the effectiveness of some of the old teaching methods, exploring new ideas and trying out new methods in different situations. Having started the MSc in Clinical Education in the past year, I find the experience extremely rewarding and enlightening. Being a product of the 'old system' of medical education where didactic teaching (lecture-based) dominated the curriculum, I found the principles of adult learning and the various techniques of small-group teaching quite fascinating. The feedback I received from medical students about the effectiveness of these techniques has been encouraging.

There is no doubt that there is an increasing demand for clinicians to deliver high-quality education, and a qualification in clinical education could become an essential rather than a desirable requirement for future consultant posts in the National Health Service.

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Medical students are generally aware of the medical responsibilities that await than on qualification, but perhaps are not as aware of the inherent teaching responsibilities that will form an integral part of their professional duties. This is no different in psychiatry, and it is commonplace to expect psychiatric trainees to take responsibility for teaching medical students on attachments, despite having received minimal training in effective teaching methods.

Although I agree with the recommendation of Dinniss *et al* (*Psychiatric Bulletin*, March 2007, **31**, 107–109) that an MSc in Clinical Education is a worthwhile qualification for consultant psychiatrists, I would argue that junior trainees in psychiatry should also be strongly encouraged to enhance their clinical teaching skills, as some trainees deliver as much teaching to medical students as their consultant colleagues.

The time constraints of combining an MSc with professional examinations could be avoided by undertaking a more manageable course such as the 1-year Higher Diploma in Clinical Teaching which is currently being offered by our

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Department of General Practice. This focuses on clinical teaching skills of explanation, effective questioning, delivering feedback, bedside teaching techniques student assessment and evaluation of teaching. Given the effect that undergraduate psychiatry teaching may have on subsequent career choice (Brockington & Mumford, 2002), it could be argued that improving the teaching skills of our trainees will pay dividends for recruitment into psychiatry.

BROCKINGTON, I. & MUMFORD, D. B. (2002) Recruitment into psychiatry. *British Journal of Psychiatry*, **180**, 307–312.

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## Have you got a right please?

The emphasis on the proposed health bill is to protect workers and the general public from second-hand smoke. Passive smoking causes about 12 000 deaths per year (Royal College of Physicians, 2005); 500 of these are due to exposure at work.

As my workplace extends to patients' homes, should I not expect the same protection as I would in an NHS building and therefore demand that a patient ceases to smoke in their own home? Community doctors and nurses, who spend vast amounts of time in patients' homes would argue that the amount of second-hand smoke inhaled per day is sometimes very high. Many of us have been in the situation where we battle through a smog of smoke just to find the patient. The next hour is painful, every breath a chore, until we hear a polyphonic wheeze deep inside our own struggling lungs. We leave and take our first heavenly gasp of fresh air, but every breath for the remainder of the day is tainted by the smell of ashtray clinging to our clothes.

Pregnant workers will understandably go to great lengths to avoid cigarette smoke and subsequent harm to their baby. Is it not their right, and some might say the right of the unborn child, to refuse to enter the house of a patient who smokes?

Of course, it is unrealistic to expect patients to stop smoking in their own homes. We could, however, follow our friends in the health visitor sector who have been requesting for over a year that patients do not smoke for an hour prior to their visit. If this practice is recognised as a condition of the visit, by previous written request, it gives health workers the right to refuse to enter the home if this is not adhered to.

Some would say that asking patients not to smoke in their own homes goes too far, adding to the 'Big Brother' milieu in which we find ourselves. Others would say that the culprits' human rights appear to be more valuable than those of the innocents, and that these rights sometimes outweigh reason. Our needs are important and we should enforce a one-hour smoking ban.

ROYAL COLLEGE OF PHYSICIANS (2005) *Going Smoke-Free: The Medical Case for Clean Air in the Home, at Work and in Public Places*. Royal College of Physicians.

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## Payment for medication

Ethical deliberations aside, bribing patients with cash to accept depot medication clearly (and perhaps fatally) contradicts the message that the medication is a worthwhile and positive offering in itself. Moreover, it cheapens and demeans the receiver who becomes one whose beliefs can be bought out for a few quid; and the giver, who becomes one who needs sugaring to be acceptable. Contradictory messages regarding the value of psychiatry are the last thing people with schizophrenia need from us, never mind our staff and the public.

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## Quality assurance of training standards

Professor Howard (*Psychiatric Bulletin*, February 2007, **31**, 41–43) highlights the training standards set out by the Postgraduate Medical Education and Training Board (PMETB; http://www.pmetb.org.uk). One of these states that all trainees must attend a departmental induction, which includes information on the curriculum, their duties and reporting arrangements.

We conducted a survey of the existing senior house officer (SHO) induction programmes in the Eastern Deanery to assess if any changes are needed to fulfil PMETB standards. Each area has a trust and local induction, which varied in format and content. Some programmes run on consecutive days and others are incorporated into lunchtime educational meetings. They all consist of sessions on medical staffing, on-call arrangements and talks by pharmacy staff. Some trusts include all mandatory training such as cardiopulmonary resuscitation, fire safety, etc. Lectures on specific skills (e.g. psychiatric emergencies), a tour of the hospital sites including the library, and meeting with clinical tutors or educational supervisors are commonly included in the induction programmes. A SHO handbook was provided by a majority of trusts. Only one trust gave an introduction to the psychiatric curriculum.

The SHO feedback showed that the most useful part of an induction programme was meeting with other colleagues and receiving practical information, including details of on-call arrangements and contact numbers. They favoured shorter sessions run over several weeks.

This survey reflects the variability of SHO induction programmes within one deanery. Clear guidance is needed to ensure the standardisation and quality of the programme throughout a region.

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## Rebound hypertension following withdrawal of clonidine

We report a 15-year-old girl with mild intellectual disability and Tourette's syndrome who also had features of hyperkinetic disorder. She had responded poorly to earlier trials of haloperidol and methylphenidate and was on 300 $\mu$g clonidine twice a day, 2 mg risperidone daily, 20 mg citalopram daily and 2 mg lorazepam a day. However, these medications were having minimal effects on her behaviour and her tics were also uncontrolled.

With no fixed protocol for clonidine withdrawal an enquiry was made to the hospital pharmacy and the manufacturer who suggested a withdrawal rate of 50 $\mu$g every third day. A week after the withdrawal regimen she was admitted as an emergency to the children's ward with symptoms of blurred vision and high blood pressure. All investigations were normal except for elevated cholesterol and triglyceride levels.

A literature search did not yield any results for a safe rate of clonidine withdrawal to avoid the potentially dangerous side-effects of rebound hypertension in children. The manufacturer, Boehringer Ingelheim, informed us that there were no recommendations for withdrawing clonidine apart from the fact that it has to be withdrawn gradually.

Since clonidine is used in children and young people to treat tic and conduct disorders, sleep disturbances, post-traumatic stress disorder, developmental