columns

changes proposed in Modernising Medical Careers and stringent record of in-training assessments, more trainees will have the opportunity to fulfil the training requirements and develop the basic psychotherapeutic skills essential for any competent psychiatrist.

We would like to propose that the College makes it mandatory that approval for a training post at SHO, specialist registrar, or even consultant level only be granted if the base hospital has a full-time or part-time consultant psychotherapist. This might apply much-needed pressure to some reluctant trusts and will certainly help to eliminate unequal opportunities which are currently present in psychotherapy in different parts of the country.

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The International Fellowship Scheme and perinatal psychiatry services in South India

I chose to work as a consultant in Manchester under the International Fellowship Scheme, so that I could gain experience with a view to setting up perinatal psychiatric services in India. The trust accommodated my needs and I was able to spend time working in the perinatal out-patient service at Wythenshawe Hospital and running special services with a perinatal psychiatric nurse in communities around North Manchester. I learnt about child protection issues, pre-pregnancy planning protocols, risk assessments and liaison with general practitioners, nurses and obstetricians. I also had the luxury of caring for several mothers and their babies at home – a novel experience. Thanks to the Fellowship Scheme, my colleagues and I have been able to set up the first formal perinatal psychiatric service for women with severe mental illness in South Asia, at Bangalore. I have also received enquiries from two other female former International Fellows who want to set up these services in other parts of South India.

Mothers who I cared for while in the UK were sad that I was leaving but were happy that I was able to help them briefly and were happier when I told them that mothers in India would now benefit from similar services! I think that I have been able to bring back somthing valuable from the UK thanks to the Fellowship Scheme.

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Medical management and clinical leadership

Am I alone in finding a distinct irony in the publication of the first two articles in the June issue (*Psychiatric Bulletin*, June 2006, **30**, 201–203 and 204–206) – namely 'Medical managers in psychiatry – vital to the future' and 'Kerr/Haslam Inquiry into sexual abuse of patients by psychiatrists'? I note in the latter paper comments by Dr Kennedy regarding 'consultants being "all powerful" ' and that 'the report challenges the absence of a clear moral and contractual obligation for all mental health professionals to report all such information, and the lack of an NHS system to maintain an accessible memory bank of all such data. Will the professions fear this as a "big brother" scenario or welcome it as an essential protection of their patients and their credibility?' These comments are made immediately after an article by Griffiths & Readhead which champions the cause of 'medical managers' and which sets out clearly their views of how 'vital' this role is to 'psychiatry'.

In my opinion these two articles highlight the inherent danger of the move by the Royal College of Psychiatrists to appoint a vice-president to promote 'medical management' with the clear aim that we continue a 'medical model' of 'medical management' where psychiatrists in these roles are seen as having great influence at strategic board and other levels and indeed over other professional colleagues.

I would respectfully suggest that this move by the College reinforces the stereotype of consultants and of medical managers being 'all powerful', as highlighted by the Kerr/Haslam Inquiry. The reality is that if we as a profession are serious about leading services into the future and providing strategic direction, we should only be given this role if we are able to demonstrate the ability to provide clinical leadership to all clinicians working within mental health services. We expect psychiatrists to work and indeed provide leadership to multidisciplinary and often multi-agency mental health teams in a variety of settings, yet at College and other levels we continue to promote a model of 'medical management' rather than a model of clinical leadership.

My opinion is that if we are serious as a College in wishing to provide leadership in both the development and provision of services in the twenty-first century then we need to embrace models of clinical leadership in which consultants engage with other professionals and accept that being a consultant gives one no divine right to act in an all powerful, inappropriate way. It is unacceptable for consultants' behaviour to be challenged only by other consultants who are 'medical managers'. If these models of clinical leadership are not adopted I fear the 'failures' identified by the Kerr/Haslam Inquiry will only be repeated in the future. This surely is the challenge for psychiatrists interested in management roles in 2006, and the College should be promoting a model in which psychiatrists are selected for management roles on merit rather than simply because they are a doctor.

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Changes to the number of CCTs will have a positive impact on training

I read with interest the eLetter from the President and the Dean of the College about the proposed changes to the number of certificates of completion of training (CCTs) in psychiatry (http://www.rcpsych.ac.uk/pdf/chnagesMay06E.pdf). No doubt these changes will have a significant impact on the future of psychiatric training at a time when postgraduate training is undergoing a radical overhaul with the anticipated introduction of Modernising Medical Careers (MMC) in August 2007.

I believe that reducing the number of CCTs from the current six to two will be beneficial to trainees for a number of reasons. First, it will bring psychiatric training in the UK in line with the rest of Europe, where psychiatrists gain accreditation in either adult or child psychiatry. A major reason for the introduction of MMC was to streamline postgraudate training in the UK, which was considered too lengthy compared with the rest of the world. Second, as reported by Day *et al* (2002), many of the issues facing UK trainees are common to psychiatrists in training across Europe.

We have certainly taken the lead in establishing a structured system of training, but we need to continue

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columns

strengthening the ties already formed through organisations such as the European Forum for Psychiatric Trainees. In today's climate of a vast increase in mobility of the global medical workforce we would do well to pay heed to the needs of our prospective employers.

DAY, E., GRIMMER, C. & LLOYD, A. (2002) Psychiatry training in Europe: a brief history of the European Federation of Psychiatric Trainees. *Psychiatric Bulletin*, **26**, 152–154.

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What's in an MRCPsych!

There is such passionate debate going on about the award of MRCPsych without examination. Those who have struggled to achieve Membership through examination feel that the value of this has been somewhat lowered or tarnished. I was awarded Membership without examination and would like to share what this means to me and what advantages it has afforded.

Has it helped me to get a job, a promotion, or a higher salary? The answer is no. It is not even recognised in India as a qualification. MRCPsych has not conferred any advantage except receiving the *British Journal of Psychiatry* and the *Psychiatric Bulletin*. I definitely did not accept an International Fellowship because of a promise of MRCPsych and I do not mention it on my curriculum vitae.

To me it means the same as my other membership of international and national societies, all of which were awarded without examinations! There is no psychiatric society in the UK of which one can become a member except the College. If one could become a member of a professional body only through their own examination, it would be good neither for the professional nor for the professional body.

MRCPsych is an expensive membership to retain. For the annual fee one could get life membership or life fellowship of at least two or three Indian scientific societies. It is not surprising that some who are awarded an honorary MRCPsych are unable to retain it after some years. As far as I am aware, no International Fellow with Membership without examinations has secured a job in the Gulf or other countries where the Membership is acceptable. I am aware of quite a few with the honorary MRCPsych who have taken up assignments in different parts of the world or international organisations. It would be futile to speculate whether the honorary MRCPsych helped them to gain these positions.

I hope those opposing the award of MRCPsych without examination will view the process from the correct perspective and not feel that MRCPsych is some exalted object which they are being robbed of. I am happy to be a member of the College and enjoy participating in its activities, and will probably retain Membership as long as I can afford it!

Declaration of interest S.K.C. was awarded MRCPsych without examination under the International Fellowship Scheme in 2004.

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Referral of older adults with dementia, acetylcholinesterase inhibitors and the NICE guidelines

Drs O'Loughlin & Darley suggest that the rate of referral of older adults with dementia has increased since the launch of acetylcholinesterase inhibitors and the publication of the National Institute for Clinical Excellence (NICE) guidelines for their use (*Psychiatric Bulletin*, April 2006, **30**, 131–134). Although the authors acknowledged the limitations of their findings, there are serious ethical and practical objections to the conclusions drawn.

We are not clear whether the 42 000 people aged 65 years and over in the catchment area was for 1996 or 2003. Fluctuation in the size of this population could easily affect the referral rate. Moreover, the authors do not define criteria used for the diagnosis of dementia in either period.

Mini-Mental State Examination (MMSE) scores are dependent on the person administering the test, age and particularly education (Crum *et al*, 1993). The difference in the mean MMSE scores between the two groups reported by O'Loughlin & Darley is just 2.8. Other cognitive scales such as the Alzheimer's Disease Assessment Scale – Cognitive subscale (ADAS–COG) or Mini-Cog have greater reliability and validity (Borson *et al*, 2005).

Hence, unless the above have been satisfactorily answered, we cannot support the tentative conclusion that more patients are being referred earlier in the course of illness to old age psychiatric services following the launch of anticholinesterase inhibitors and publication of the NICE guidelines.

BORSON, S., SCANLAN, J. M., WATANABE, J., *et al* (2005) Simplifying detection of cognitive impairment: comparison of the Mini-Cog and Mini-Mental State Examination in a multiethnic sample. *Journal of the American Geriatric Society*, **53**, 871–874.

CRUM, R. M., ANTHONY, J. C., BASSETT, S. S., *et al* (1993) Population-based norms for the mini-mental state examination by age and educational level. *JAMA*, **269**, 2386–2391.

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Statistical assessment of MMSE scores

It is disappointing that the interesting study by O'Loughlin & Darley (*Psychiatric Bulletin*, April 2006, **30**, 131–134) was let down by the use of inappropriate statistics. Since scores on the Mini-Mental State Examination (MMSE) constitute data that are ordinal in nature, it is not appropriate for the mean to be presented as a measure of central tendency. For the same reason, it is not appropriate for standard deviation to be offered as a measure of dispersion. Use of the median and interquartile range (IQR) would have been more appropriate. Similarly, use of the *t*-test as a test for difference between the two groups was ill considered because MMSE scores in both study populations are negatively skewed. The authors should have used a non-parametric test for difference such as the Mann–Whitney *U*-test.

For the record, the median MMSE score was 20 (IQR 16–24) in the 1996 sample and 22 (IQR 19–25) in the 2003 sample. Running the authors' data through a Mann–Whitney test on StatCrunch (available at http://www.statcrunch.com) still finds a significant difference between the two groups (P=0.0037).

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Authors' reply The nature of pragmatic research is to examine clinical practice in the manner it happens – that is both its weakness (for example, not using research-standardised diagnostic interviews or detailed cognitive testing) and its strength. The MMSE has been in use in both clinical and research settings since 1975 as a tool for cognitive assessment and Drs Kripalani and Poongan are correct in stating the unreliability of a single cut-off point for any diagnosis. In our study we examined MMSE scores only of those patients with a diagnosis of dementia, and

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