

enthusiasm for teaching, but optimising the student experience is crucial, so novel ways of controlling quality must be sought.

The results of this survey will be used to inform changes to this particular teaching programme such as increasing the use of role-play teaching and emphasising the importance of structured firm teaching, with regular consultant tutorials as well as sessions with junior doctors. The findings could also inform adjustments to psychiatric teaching programmes at other institutions. More studies examining the specific components of undergraduate teaching programmes in psychiatry are required to establish which teaching methods students find most stimulating and which aspects need improvement. Shaping teaching programmes in this way may improve the overall undergraduate experience of psychiatry for students and perhaps even help recruitment into the specialty.

- 1 Simmons M, Wilkinson P. Lectures versus case discussions: randomised trial of undergraduate psychiatry teaching. *Psychiatrist* 2012; **36**: 146–50.

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The psychiatry experience from a medical student perspective

I am a third-year medical student in the last week of psychiatry rotation. Although many positives emerged from this experience of psychiatry, it is clearly useful to identify areas of weakness, as a good undergraduate experience is crucial to encouraging recruitment into the profession.

The first challenge facing my curriculum is from sharing timetable space with neurology in a 'brain-and-mind' rotation. It is perhaps an indictment of attitudes towards mental health that psychiatry is found in this position, something which is not required of my other third-year rotations. The very title 'brain and mind' is fatally misleading, insidiously suggesting that neurology is the 'brain' (i.e. the challenging, scientific area), whereas psychiatry is relegated to the 'mind' (and by association, the opposite) by medical school and students alike. I have observed the damage to the attitudes of students previously sanguine towards psychiatry originating from this false and simplified dichotomy.

With psychiatry being the Cinderella of the 'brain and mind' rotation, the contrast with the 'brain' of neurology is stark. Neurology lectures are delivered by a locally eminent neurologist, whereas a majority of the psychiatry lecture curriculum is delegated to nurses trained in medical education. I cannot be alone in suspecting that it would be considered unthinkable for the neurology component to be delivered by nurses, yet somehow this attitude is acceptable and pervasive in psychiatric undergraduate education. Part of a wider stigma, perhaps? That, of course, is not a criticism of the teaching delivered by the psychiatric nurses (and the multidisciplinary approach is vital in psychiatry), but if attitudes (and therefore recruitment) are to improve among medical students, then it is essential that psychiatrists lead the taught curriculum. Not only would this potentially raise standards, but also provide students with psychiatric role models. Most can recall doctors or professors from their undergraduate years who were near

idolised by students. To create this culture in psychiatry would give students considering a career in psychiatry a template of how they can progress. At present, however, psychiatrists are seldom found on the ward, or delivering lectures (a common issue raised by other schools). There is great difficulty even finding psychiatrists to facilitate the psychiatry problem-based learning. The blame for these problems is not confined to one organisation and progress is being made.

Nevertheless, I have enjoyed my psychiatry rotation and have been steeled towards the specialty as a career. It is encouraging to see a more evangelical approach to recruitment being propagated by the Royal College of Psychiatrists, and I look forward to the debate continuing.

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Driving in a crisis

We wholeheartedly commend Dr Sheridan on his recent article on fitness to drive¹ and thank him for highlighting such an important issue.

All drugs acting on the central nervous system can potentially impair alertness, concentration and driving performance. This is particularly so at initiation of treatment, soon after and when dosage is being increased. Driving must cease if adversely affected. Doctors have a duty of care to advise their patients of the potential dangers of adverse effects from medications and interactions with other substances, especially alcohol. The Driver and Vehicle Licensing Agency (DVLA) has published a list of psychiatric conditions and the requirements for notification. Its directives make clear distinction between group 1 drivers (of cars and motorcycles) and group 2 drivers (of lorries and buses). To regain the licence, the DVLA must be satisfied that an improvement in the mental state has been achieved and a period of stability has been fulfilled, which varies for every condition and between groups 1 and 2.² Crisis resolution teams deal on a daily basis with most of the psychiatric conditions which should be declared to DVLA, such as severe anxiety states or depressive illness, acute psychotic disorders of any type, hypomania/mania, chronic schizophrenia, personality disorders, and substance misuse. In addition, driving can be used as a means of suicide or as a means to harm others, which emphasises the need of a thorough assessment, accurate documentation and regular review. There are a number of incidences such as the tragic event of a mental health service user who lost control behind the wheel killing herself and two members of the public.³

I believe the assessment of fitness to drive should be incorporated in day-to-day risk assessment and clearly documented at each contact with crisis team service users. This is core business of every professional who comes in touch with patients. Patients deserve to be advised with regard to DVLA regulations, and indeed should stop driving if deemed unsafe and advised to contact the DVLA accordingly. The General Medical Council advises clinicians to tell patients with conditions which are likely to impair their ability to drive to inform the DVLA. If, however, the clinician does not assess and monitor the particular risk, they would be failing in their statutory duty, irrespective of their need to break confidentiality or not.⁴

- 1 Sheridan MP. Assessing fitness to drive in dementia and other psychiatric conditions: a higher training learning opportunity at a driving assessment centre. *Psychiatrist* 2012; **36**: 113–6.
- 2 Driver and Vehicle Licensing Agency. *At a Glance Guide to the Current Medical Standards of Fitness to Drive (For Medical Practitioners)*. DVLA, 2012 (<http://www.dft.gov.uk/dvla/medical/ataglance.aspx>).
- 3 NHS East Midlands. *An Independent Investigation into the Care and Treatment of a Person Using the Services of Leicestershire Partnership NHS Trust (Ref. 2007/197)*. East Midlands Strategic Health Authority, 2010.
- 4 General Medical Council. *Confidentiality: Reporting Concerns about Patients to the DVLA or the DVA (Supplementary Guidance)*. GMC, 2009 (http://www.gmc-uk.org/Confidentiality_reporting_concerns_DVLA_2009.pdf_27494214.pdf).

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Anecdote about Denis

May I please add a personal note to your obituary of Dr Denis Murphy?¹ Denis returned to Britain at about the same time as I returned from Australia. Before our eventual careers took shape, we tended to follow each other around south London experiencing what Denis often referred to as 'A plague of locums', and became friends.

A biological psychiatrist in those days, his attachment to general medicine was keen, as shown by an incident in Dublin one night when I happened to be visiting. We had taken his mother to a fine performance of Wilde's *A Woman of No Importance*. It was dark and raining on the return to Terenure when we encountered a policeman directing traffic around a badly injured motorcyclist. Denis stopped the car and insisted on offering his (and my) services. There followed, for an inordinate length of time before the ambulance finally arrived, the improbable scene of two sodden psychiatrists attempting mouth-to-mouth CPR on an all-but-moribund youth as cars went by, perilously close, either side.

Typically, wanting to know the outcome of our efforts, Denis rang the hospital the following day. The accident victim was deep in a coma and not expected to recover. Putting down the receiver, my friend remarked, philosophical as ever, 'At least we saved his kidneys for somebody!'

I shall long remember the near-mischievous twinkle in his eye, and the perfectly expressive, wry, lopsided grin, which accompanied this observation. They captured the very essence of his charm.

- 1 Hollis P. Dr Denis Murphy. *Psychiatrist* 2012; **36**: 198.

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Competition and choice

Sugarman's commentary¹ strikes me as rather missing the point. I did not take Mynors-Wallis² to be criticising practitioners working outside of the National Health Service, but instead to be looking critically at the evidence that competition is the best mechanism for improving care. Sugarman makes much of the value of patient choice in improving services, although does not cite any evidence in

favour of this assertion. In many mental health settings, this is also disingenuous. Our patients do not have any choice, instead it is the primary care trusts (PCTs) who make choices on their behalf. Even with the most benign possible view of these arrangements it is hard to believe that PCTs make their decisions on the basis of the wishes of the patients or their families as their primary concern. It may be that PCTs are, in fact, fantastically good at choosing the best, highest-quality, and most cost-efficient healthcare, but let us not pretend it is about patient choice.

- 1 Sugarman P. Diversity and choice in mental healthcare. Commentary on . . . Cooperation or competition? *Psychiatrist* 2011; **35**: 443–4.
- 2 Mynors-Wallis L. Cooperation or competition? Proposed changes in healthcare provision in England. *Psychiatrist* 2011; **35**: 441–3.

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Royal College examination fees surplus

At the current level of membership examination fees at the Royal College of Psychiatrists, a resident in psychiatry who passes every part first time pays a total of £2136.¹ These costs are intended to cover only expenses rather than to generate profit, a message which many of us have accepted and disseminated.² We were therefore disappointed to learn recently that in 2010–2011, the College made a profit of approximately £1.5 million from exam fees. Some residents are understandably asking for candidates to receive a refund, a process for which there is historical precedent.³

We have another suggestion for how this money could be put to good use for the benefit of residents, the College and psychiatry as a whole. The College's annual International Congress currently receives about £70 000 from pharmaceutical companies and other organisations in return for exhibition space (personal communication with the College's Conference Office). Such relationships are undesirable because drug company information affects prescribing.⁴ Most doctors do acknowledge this to be true of their colleagues, although the majority believe they are themselves, of course, unaffected.⁵ Further, and particularly pertinent to psychiatry, is the effect that drug company relationships may have on our patients' confidence in our treatment recommendations. Many detained patients are suspicious that psychiatrists' prescribing is motivated by connections with the pharmaceutical industry rather than a genuine intention to improve mental health. We acknowledge the College's considerable progress in the right direction over the issue, but it is problematic to deny such allegations while promotional materials continue to be welcome at our annual congress.

If the surplus from examination fees were used to subsidise the International Congress, it would be possible to have no commercial exhibitor fees for at least 10 years, by which time alternative arrangements could be made. Furthermore, some of the surplus could be 'given back' in the form of bursaries for residents to attend the conference. This course of action would allow the College to lead by positive example, while providing wider benefits for UK psychiatrists and our patients.

- 1 MRCPsych Examinations Calendar 2012: <http://www.rcpsych.ac.uk/pdf/MRCPsych%20Examinations%20Calendar%202012%20130212.pdf>