Psychiatric Bulletin (1993), **17**, 240–247

Correspondence

Dementia in medical students

DEAR SIRS

The cognitive assessment of a patient is an integral part of the mental state examination. There are several standardised rating instruments to assist in this assessment, but correct scoring is dependent upon the psychiatrist himself being cognitively intact. Our general impression of students undertaking their psychiatry attachments suggested that they had difficulty in answering some of the questions. We therefore wish to report the results of a study undertaken to examine this.

Individuals within two consecutive groups of medical students attached to the psychiatry department were cognitively assessed. The rating scales employed were the information/orientation subtest of the Clifton Assessment Scale (Pattie & Gilleard, 1975), the Abbreviated Mental Test (Hodkinson, 1972), and the memory items of the Camcog section of the Camdex.

All 42 students agreed to the cognitive assessment (100%). On the Abbreviated Mental Test, 21 students (50%), scored the full marks of 10/10. A score of 9/10 was gained by 20 students (47.6%), and one student (2.4%) scored 8/10. The item most commonly failed was the date of the first world war. Using the Clifton Assessment Scale, full marks of 12/12 were gained by 35 students (83.3%), with seven students (16.7%) scoring 11/12.

Low scores were gained on the memory items of the Camcog. The maximum score on this scale is 27. The mean score obtained by the students was 21.7, with a range of 14–25. Common errors included naming Lindberg (42 students; 100%), naming Stalin (27 students; 64.3%), the dates of world war one (22 students; 47%) and world war two (16 students; 38.1%) and describing what Mae West was famous for (18 students; 42.9%).

The Camdex is a comprehensive instrument developed as a valid and reliable measure of the extent of cognitive impairment, which is the central feature in established dementia. High sensitivity and specificity in distinguishing dementia and acute confusional state from functional psychiatric illness or no illness have been demonstrated. The memory items of the Camcog are only one part of the overall instrument; however extrapolation of the original study suggests scores less than 20 to indicate dementia. Using this criteria, ten medical students (23.8%) were inflicted with dementia. We were initially concerned by this finding until, on reflection, we recognised the potential benefit to those demented patients in contact with these students. The demented medical students would be more able to empathise with their demented patients.

The Abbreviated Mental Test corresponds to the ten most discriminating items of the Roth and Hopkins (1953) test of information – memory – concentration; distinguishing well between people with dementia or acute confusional state and people with no illness. Surprisingly, none of the demented students scored below the dementia cut-off of seven. Similarly, reasonable scores were achieved on the Clifton Assessment Scale.

The Camdex was validated on people who were over the age of 65 years in the early 1980s, and its use should be confined to this population. As successive age cohorts grow older, questions within rating scales require updating; medical students may be able to describe Madonna but not Mae West. Psychiatrists who instruct medical students must remember to teach them not only always to conduct a cognitive assessment on the patient, but also what the answers are.

The Bachelor of Medicine examination in psychiatry was passed by 98% of this group of students.

SALLY-ANN COOPER
STEPHEN J. FROST

Mental Illness Unit,
Leicester General Hospital,
Gwendolen Road,
Leicester LE5 4PW

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PATTIE, A. H. & GILLEARD, C. J. (1975) A brief psychogeriatric assessment schedule. Validation against psychiatric diagnosis and discharge from hospital. *British Journal of Psychiatry*, **127**, 489–493.

ROTH, M. & HOPKINS, B. (1953) Psychological test of performance in patients over 60. I. Senile psychosis and the affective disorders of old age. *Journal of Mental Science*, **99**, 439–450.

Feedback from patients after public campaigns

DEAR SIRS

I publicly raised some concerns about the College's 'Defeat Depression' campaign (*Guardian* Letters,

15.2.92). Later, the *Sunday Times* made further use of what I said (11.10.92). Here is an example (supplied with the writer's interest and approval) of what people subsequently wrote to me:

> "After a severe depressive illness 25 years ago, I could write a book about the tortuous road back to so-called normality, having run the whole gamut of drugs, ECT, psychotherapy and abreaction etc. In order, hopefully, to be helpful and not presumptuous, could I make a few suggestions:
> 1. Let the patient try and tell you *exactly* how he/she feels and never tell him you know how he feels – you can't, possibly!
> 2. Participating treatments are far more useful than passive ones – even if the patient has to be cajoled into cooperation. An anxious depressive will probably be far more cooperative.
> 3. If your patients are reasonably articulate, why don't you follow them up, a year or so after they have been well, and ask them about their experience – how they felt about their illness – how the illness itself felt – which aspects of treatment helped them and which they found distinctly unhelpful.
> 4. If they are not particularly articulate, they may find it easier (and, from experience, *very* helpful) to write down their feelings, however jumbled the final result may seem.
>
> I write this entirely to give you suggestions from "the other side of the fence" and hope that maybe there is something useful."

Unexceptional suggestions, perhaps, but presumably things this very reasonable person did not find enough of in her long experience. Of course, different people may find different things helpful. Formal research and less formal audit may touch some of these areas, but only within the limits of the questions the *professional* chooses to ask.

May I suggest that, in its public campaigns, the College incorporates a genuine, open interest in receiving this kind of feed-back and advice, however much we may think it produces nothing we do not already do in our practice? Perhaps it should be a constant feature of specific campaigns like Defeat Depression, although why not a campaign of its own too? Wouldn't it be an impressive statement of the College valuing those who have been on "the other side of the fence" – indeed, it would show that psychiatrists seek collaboration not the divisiveness implied by "fences"?

I propose that the College – on its own, or co-operating with MIND and "user" groups – sets up a formal system to publicise the invitation, and then collects, edits, and publishes such correspondence into some easily accessible form. Perhaps there could be an appendix of references to other published subjective descriptions of the experience of mental health problems and their treatment (see Further reading, below, for examples)?

This project would certainly be a collaborative effort – both sides of the fence would equally find the result an extremely useful resource.

NICK CHILD

Child and Family Clinics
49 Airbles Road
Motherwell Scotland
ML1 2TJ

Further reading

GALLOWAY, J. (1989) *The Trick Is To Keep Breathing*. Minerva.

PLATH, S. (1963) *The Bell Jar*. Heinemann; Faber.

PODVOLL, E. (1990) *The Seduction of Madness*. Harper-Collins; Century.

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Reply

DEAR SIRS

Dr Child proposes, *inter alia*, formal systems for responding to the views and the correspondence from patients. I am sure that he will be pleased to hear that the College already has measures in place for such purposes.

In the 1992 annual report of the Royal College of Psychiatrists there was an article on the Patients' Liaison Group. One of the aims of this Group was to make the College aware of patients' concerns, and it was to provide a forum for a continuing dialogue between psychiatrists, patients' groups and carers. The Group is chaired by Professor Brice Pitt. It includes representatives from a wide variety of patients' and carers' associations. The Group reports to the President, to the Public Policy Committee, to the Executive and Finance Committee and to Council.

Patients' letters coming to the College are replied to usually by Professor Philip Seager. Letters particularly concerned with the Defeat Depression Campaign are replied to by Dr David Baldwin.

I shall pass Dr Child's letter on to Professor Pitt, Professor Seager and Dr Baldwin, since they may wish to take up some of Dr Child's other interesting proposals.

R. G. PRIEST

Chairman, Defeat Depression Campaign

Training in psychiatry

DEAR SIRS

The dispute between the Maudsley consultants and Professor Copeland (*Psychiatric Bulletin*, 1992, **16**, 798–799) about the training status of senior registrars seems old fashioned.