Nurse prescribing is a contentious issue (*Psychiatric Bulletin*, April 2008, **32**, 136–139). Although the benefits of a multi-disciplinary approach to prescribing cannot be overstated, there are two potential problems. The main pitfall is the discrepancy between ability and expectation. Prescribing medication without knowledge of physiology and pharmacology is a recipe for disaster. Years of medical school training coupled with hands-on experience cannot be matched by training through prescribing courses.

The second equally important issue is related to psychiatric training for junior doctors. Nurses taking over such tasks as prescribing and mental state assessments will reduce the training opportunities for junior doctors who are already recovering from the double blow of the European Working Time Directive and a curtailed 6-year run-through system. There is a risk that their role might gradually be restricted to chasing blood tests results, carrying out physical examinations and dictating summaries. In the course of time, a cohort of 'trained' psychiatrists may emerge with potentially less hands-on experience. Expecting them to oversee risk management might be a little unreasonable.

Declaration of interest

A.H. is a run-through trainee at ST3 level.

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Making the most out of the Gold Guide

While some of the trainees have not yet completely recovered from the stormy entry into the run-through system, others are about to face their annual review of competence progression. The Postgraduate Medical Education Training Board has set out clearly the operation of the competence-based specialty training in the UK. Its offshoot product, the 'Gold Guide' (Modernising Medical Careers, 2007), seems to be the Bible to follow in the new era of training. However, several months into the system this 'golden guidance' has yet to become popular among trainees. Of particular interest is the section which explains three integrated components of the process, the 'three As' – appraisal, assessment and annual planning.

The appraisal should be a continuous process happening at regular intervals. In my opinion, it is the crucial part of the review. The importance of educational supervision was also highlighted by Day & Brown (2000) and Sembhi & Livingstone (2000). The assessment seeks clear evidence and proof of achievement in both performance (workplace-based assessments) and experience (log book, audit and research). Based on this, the trainees' future needs can be identified (annual planning).

The annual review of competence progression appears a well-considered plan. However, there are some inherent difficulties in its implementation, particularly in psychiatry. For the specialty trainee year 4, identifying educational supervisor other than a clinical one has been an issue. Research sessions and special interest sessions have not been considered in the review, probably because traditionally they have not been part of other specialties' training curriculum. Therefore, for example, getting a report from research supervisor for the review is not feasible. Some centres have only 4-month training posts for specialty trainees years 1–3, too short for any effective appraisal process. The most burdensome aspect at the moment seems to be nominating people and getting feedback from the multidisciplinary team through the online system. Trainees can easily find themselves frantically running around to get the forms filled.

Notwithstanding, this system is a better way of testing and developing competence progression. It has given us the opportunity to be reflective in our learning experience and it has managed to merge clinical and educational supervision in the best possible way. It is bound to have some initial hiccups, but the best way to deal with them is to take an optimistic approach, familiarise with the Gold Guide and get on with the tasks.

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Recruiting psychiatrists – the Singapore experience

In view of the current shortage of psychiatrists worldwide, it is important to understand the impact of an undergraduate posting in psychiatry on medical students (Brockington & Mumford, 2002). Earlier studies showed that postings in psychiatry can positively influence students' attitudes and knowledge about the specialty. We conducted a pilot study to examine the influence of a posting in psychiatry on the career plans of medical students (Holmes-Peterson *et al*, 2007; Cutler *et al*, 2006). Third-year students (n=72) in Singapore filled out a 30-item self-report survey after their 4-week clinical posting in psychiatry. The questionnaire examined the preferred specialty before entering medical school, the change in attitude towards psychiatry after the posting, the consideration of psychiatry as a career after the posting and the reasons for that.

The majority of students indicated an improvement in their attitude towards psychiatry, in tune with earlier studies worldwide. About 39% had a preferred specialty before the psychiatry posting. For male students it was surgery, followed by orthopaedic surgery, and for female students, obstetrics and gynaecology, followed by paediatrics and surgery. Only one student preferred psychiatry before the posting. After the posting, 68% wanted to consider a career in psychiatry – 20% of this group had indicated a specific non-psychiatric career choice earlier on. Experience during the posting was the most important factor for changing their career plans (this was regardless of the students' gender).

The study showed that posting in psychiatry can have a direct influence on (re)consideration of psychiatry as a career option in undergraduates. Although Eagles *et al* (2007) reported that most definitive career choices will be made during the (early) postgraduate years, our findings are encouraging and more research in this area could be beneficial to improving the recruitment of future doctors into psychiatry.

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Montelukast and worsening of hallucinations in paranoid schizophrenia

A 29-year-old woman was admitted to a psychiatric in-patient unit with a history of schizophrenia. She believed that she was being raped by strangers and that people were performing witchcraft on her. She also had third-person auditory hallucinations. As the patient's symptoms did not subside with her regular antipsychotics (quetiapine 750 mg once daily), she was considered suitable for clozapine. Later, this was contraindicated as her pulse rate was above 100 beats per minute, which was possibly related to her poor asthma control (electrocardiogram – normal QTc). The patients' antipsychotics remained unchanged, but after the review by the respiratory team, she was prescribed montelukast (10 mg once daily). In 48 hours she started to have increasing hallucinations about a spider crawling up from her abdomen to her face and biting her. She was worried that she had marks on her face and that she needed to camouflage them. She reported seeing her dead brother and talked about a 666 mark on her scalp which she saw in the mirror while combing her hair. There were no signs of delirium and the patient's Mini-Mental State Examination and blood tests were within normal limits.

We thought it possible that montelukast was aggravating the somatic and visual hallucinations and the medication was stopped. After 2 days the new symptoms subsided completely. Though some of the previously present psychotic symptoms were still there, the patient was less agitated than when on montelukast.

Hallucinations are rare side-effects of selective leukotriene receptor antagonists like montelukast (www.drugs.com/sfx/montelukast-side-effects.html). The *British National Formulary* reports hallucinations as one of the side-effects of montelukast, but does not advise caution in schizophrenia or psychosis. Montelukast has been associated with adverse reactions such as abnormal dreaming, nightmares, hallucinations, agitation irritability and restlessness, which suggest that it can penetrate the blood–brain barrier (Price, 2000; Netherlands Pharmacovigilance Centre, 2007). A causal relation between montelukast and psychotic disorders and/or schizophrenia has not been established and is still unclear.

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Questioning and answering exams

The birth pangs of the revised College membership exam (MRCPsych) format are interesting to follow (*Psychiatric Bulletin*, December 2007, **31**, 441–442; April 2008, **32**, 152).

Though the essay and critical appraisal papers drove herds of trainees to hunt for journals, by and large it sadly remained a one-off affair. The College made a laudable attempt to cure this brief erotomania with the development of structured workplace-based assessments that qualitatively and quantitatively test the application of breaking news from the journals to clinical practice. This would ensure that the trainees use information from high-impact journals continuously and, by proxy, test the foetal findings from the laboratories in the real world of restricted resources.

The multiple choice questions, provided they are meaningfully structured to combine scientific facts and clinical practice, should test the trainees' credentials or at least their recognition skills. I was distraught to find that the cut-off to pass Paper 2 was 39.8% (personal communication) and that roughly one in three trainees had passed. This to me means that the impetus of the College is tangential if not diametrically opposite to the focus of the trainees. This situation needs to be rectified with utmost urgency. Another hypothetical and thoroughly amusing argument is that the essay paper had enhanced the writing skills of the trainees. I am awaiting a study that will find a correlation between the trainees' scores on the essay paper and the number of their publications.

The process of changing exam patterns is an immortal amoeba. The best pseudopodia now are multiple choice questions. Whether they will breathe fresh fragrance or turn into a storm uprooting the validity of the exams will only become discernable with the passage of time.

Declaration of interest

V.R.B. is a problem-based learning tutor and is involved in the MRCPsych teaching programme at the Norfolk and Waveney Mental Health Partnership NHS Trust.

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Power and glory

Fifty-eight nominations for election to the Council of the British Medical Association have been received this year. None is a psychiatrist (although two have not specified a specialty), yet psychiatry is one of the largest fields of medicine in terms of medical staffing. Does this lack of engagement with national medical politics reflect a feeling of marginalisation within the medical workforce? Do we feel national medical representation does not reflect our needs? As a member of a regional consultants and specialists committee I find that I need to remind other members that psychiatry is not a 'minor' specialty.

In order to be seen as part of the mainstream, we need to continue to think of psychiatry as a mainstream career.

If we were organised and motivated psychiatry would be able to dominate the world of medical politics – perhaps to everyone's advantage.

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