It seems that the response to our review touches upon two issues relating to telepsychiatry: inequality in access and virtual clinical rotations. As we recognised in our paper, much of the literature has traditionally focused on English-speaking and/or more developed countries. This does pose a risk of skewing data and not representing the intersecting needs of the communities served by telepsychiatry. We would urge future researchers to continue to consider this specifically when designing studies or reviewing the literature.

In relation to the virtual clinical rotations, the emerging research does pose interesting questions about a possible future format for education. This harkens back to the purported origins of telepsychiatry in the 1950s, when it was used for long-distance medical student teaching. We do wonder what the risks would be of moving electives or clinical rotations from face-to-face to virtual. Would students be able, for example, to develop understandings of team working and institutional dynamics? Would they too miss out on the formative phenomenological experiences of being with patients and their families?

Telepsychiatry is effective and likely to continue to be present in many healthcare systems around the world. As clinicians, though, we must strive to ensure that future iterations of virtual medicine remain safe for professionals and patients alike.

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None

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The case for routine screening for e-cigarette use in psychiatry

Smoking e-cigarettes, also known as vaping, has become an increasingly common practice in the past decade, with recent estimates of lifetime prevalence of 23% globally.[1] Despite this, the incidence of documentation of e-cigarette use in medical records by clinicians remains relatively low,[2,3] perhaps indicating that e-cigarette use is not routinely screened for or that patients do not inform clinicians about their use.

As smoking e-cigarettes is a relatively new phenomenon, there remains a paucity of literature regarding its adverse effects. However, recent research has demonstrated a host of side-effects, including but not limited to cytotoxicity, oxidative stress and pulmonary injury.[4] Although the impacts on mental health remain largely unknown, a recent cross-sectional study by Oh et al found a positive correlation between vaping and psychotic experiences in college students in the USA, even after adjusting for marijuana use and the presence of depression or anxiety.[5] Similarly, a recent scoping review found positive associations between e-cigarette use and depression, suicidal ideation and suicide attempts.[6] Although these findings do not necessarily suggest a causative relationship, especially acknowledging the significant heterogeneity among e-cigarette devices, these studies do indicate a potential link between e-cigarette use and mental illness.

As such, there may be benefit to routinely screening for e-cigarette use in a standard mental health history. Data derived from health services, as well as individual clinician experiences, can assist in determining the potential risks of this increasingly popular practice moving forward.

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Declaration of interest

None

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I aim to specialise in acute paediatric mental health; why isn't psychiatry the obvious choice for training?

Given the theoretically large overlap in care provided by psychiatrists and paediatricians, young people's mental health

should be exceedingly well provided for and managed. However, we know of nationally chronic provision issues in child and adolescent mental health services (CAMHS) and a disconnect between mental health and physical healthcare provision across paediatric services. Many still claim that 'paediatricians are the last real generalists'.[1] If that generalism doesn't encompass mental health, is anyone a generalist anymore?

Through placements and medical jobs, specific cases stay with you. Across the course of several medical school placements in paediatrics, those individual cases had one common theme – a mental health component. Whether it was the remarkable attention to detail in the case of a 12-year-old admitted with severe gastroenteritis who had a history of self-harm, or the occasion where a covering consultant simply 'didn't know what to say' to a 10-year-old on their first admission with an eating disorder, the commonality between these cases was that the mental health factor stood out like a beacon to every member of staff like no other comorbidity or patient-specific factor.

During my first job as an FY1 doctor, I experienced this challenge of care in a much more acute capacity. Working in an acute psychiatric hospital, I was asked to assess a 15-year-old girl with a head injury. She was being held in the 'place of safety', a temporary facility for acutely unwell patients pending transfer to an appropriate ward (in this case, out of area). Owing to several episodes of headbanging, the patient had a severe head swelling, bilateral racoon eye bruising and unequal pupils on my assessment. In any other case, whether paediatric or adult medicine, this would be someone deemed to require urgent medical assessment. But owing to the compounding mental health factor, who did the duty of care fall to? A lack of coherence between the medical and psychiatric teams became evident extremely quickly. I was told that the risk of transfer was a psychiatric decision but then in rebuttal was told that the urgency or need for transfer was purely a medical decision. It was not a straightforward evening.

In adult medicine, a stroke team is more than well equipped to manage a patient's concurrent pneumonia. On a paediatric ward, the generalists that are the paediatricians are easily able to manage a patient's diabetic ketoacidosis alongside an asthma exacerbation. But when it comes to mental health, we see that this ability to manage, at least acutely, lags. There is change on the horizon. The Royal College of Paediatrics and Child Health have introduced a SPIN module for mental health which simply offers some structured additional training.[2] The Royal College of Psychiatrists currently has a run-through pilot for CAMHS, which has been running since 2018.[3] My personal ambition is to specialise in acute paediatric mental health – where do I go?

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Declaration of interest

None

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