columns

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An elegy to essay writing

Benning & Broadhurst (*Psychiatric Bulletin*, December 2007, **31**, 441–442) raise an important issue with regard to the change in the MRCPsych exam format. In addition to the loss of long case, the new exam discards essays and critical appraisal in theory assessment. The loss of essay, in my opinion, deserves significant mourning.

Essays have traditionally been the only mode of testing logical arguing skills. This is an essential skill for any clinician in psychiatry given the intangible nature of certain domains of our clinical work. In the absence of a well-constructed arguing ability, team working and teaching cannot flourish.

Essays tested contemporary contents, unlike multiple choice questions which were obtained from a bank of questions. The creativity and reasoning abilities of a candidate are largely untested in the new format exam. This means we might get many qualified specialists in the future who read the specified syllabus and managed their time well at Clinical Assessment of Skills and Competencies (CASCs, formerly OSCE exams), though they never had a chance to prove that they are up-to-date with the developments in psychiatry or that they could think critically about a controversial issue in the field. This is a great loss as the aforementioned are important and distinguishing skills for any psychiatrist.

I am a candidate who sat the last of old pattern MRCPsych part 2 exams and, like most of my peers, I spent a substantial amount of time researching the *British Journal of Psychiatry*, *Advances in Psychiatric Treatment* and *Psychiatric Bulletin*, as well as other journals, when preparing for my exams. Journal reading habit was cultivated strongly by essay papers in MRCPsych. This is not the case with multiple choice questions. Factual recall is tested equivalently by both multiple choice questions and essays (Palmer & Devitt, 2007), but higher order cognitive skills including problem-solving cannot be easily tested by a set of questions (Schuwirth *et al*, 1996). It is, moreover, everyone's secret that the College uses a bank of questions with a high repetition rate for subsequent exams.

One argument against essay writing is standard of assessment, which could vary widely when an essay is evaluated. Standardisation of assessment could be attempted by structured essay evaluation tools. Removing essay writing completely and replacing it with multiple choice questions is a costly trade-off between assessment standards and abilities tested.

Multiple choice questions may be an easy option if one considers online delivery of exam modules in the future, but whether we need to give up on essay papers is a matter of serious debate. Fast food may be easy and appealing, but cannot solve all nutritional requirements!!

Declaration of interest

L.P. was awarded Laughlin prize for outstanding performance in old format MRCPsych exam, Autumn 2007. He is also involved in writing a multiple choice questions' book for the new format MRCPsych.

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SCHUWIRTH, L. W. T., VAN DER VLEUTEN, C. P. M. & DONKERS, H. H. L. M. (1996) A closer look at cueing effects in multiple-choice questions. *Medical Education*, **30**, 44–49.

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The art of psychiatry

I read with interest the article by Benning & Broadhurst (*Psychiatric Bulletin*, December 2007, **31**, 441–442). Holism has become such a cliché in psychiatry. It is sad that at a time when other specialties are embracing the humanities, psychiatry seems to have started to neglect it.

Psychiatry has made a lot of progress over the last few decades. Paging through psychiatric journals filled with imaging studies and genetic breakthroughs showing remarkable discoveries, one can fully appreciate the changes that have been made. In response to these advances in psychiatry Dr. David J. Hellerstein argues that, 'In exploring these new universes, we need not be only technicians and scientists, but also artists!' (Hellerstein, 2007).

The pressures on seeing patients within specified targets and this affair with all things biological has an impact on our patient care. This reductionist psychiatry with quick consultations and quick fixes fits in with the consumer society of 'just add water and stir'. It is unfair to expect a pill to fix complex psychosocial problems.

It is all well and good to have holistic training, but you also need the support and resources to implement the techniques you have learned. In the proposed New Ways of Working we are expected as doctors to only see the most complicated cases. Hopefully, in this new scheme, there will be more time allocated to spend with patients and provide them with a more holistic treatment. Teaching will give the foundation to build from, but without the resources to implement holism they will become forgotten poems.

HELLERSTEIN, D. (2007) *The Disappearing Patient*. Medscape General Medicine (http://doctor.medscape.com/viewarticle/560699).

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Utility of the electroencephalogram

While the electroencephalogram (EEG) has been available to psychiatrists for over 30 years, its usefulness in psychiatry remains unclear. One study shows that the yield appears low in psychiatry, particularly for epileptic disorder which is fundamentally a clinical diagnosis (Stone & Moran, 2003). However, this contrasts with Fenton & Standage's (1993) finding that 92% of EEGs were useful in a psychiatric series.

We compared the requests from psychiatrists for EEGs with the corresponding report in 186 tests (patient group aged 16 years and above, trial over a 28-month period, target population 924 000). This information is held electronically, but we also inspected the original written request in a quarter of cases.

Clear abnormalities suggesting epilepsy or cerebral dysfunction were found in 15% of the study cohort (9% of <65 years old, 39% of ⩾65 years old). We defined a test as being useful if it was either clearly abnormal or clearly normal and was likely to add diagnostic weighting in the context of the information on the request form; this usefulness was found in 37% of tests (32% in <65 years old, 55% in ⩾65 years old). The apparent usefulness was reduced if suspected cases of epilepsy were excluded, which happened in 19% of tests (16% in <65 years old, 35% in ⩾65 years old).

In terms of abnormal positive results for epilepsy, there were no tests supporting unsuspected epilepsy; however, 7 out of 96 in the younger group and 2 out of 26 in the older group did support suspected cases of epilepsy. For cerebral dysfunction, there were 5 out of 45 suspected

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and 2 out of 103 unsuspected instances in the younger group, and 2 out of 9 suspected and 11 out of 29 unsuspected in the older group. The division between suspected and unsuspected cases was dependent on the quality of the referral, which was often limited.

Our findings suggest that the EEG gives useful diagnostic information in a little over a third of cases. However, in practice the effect is likely to be reduced by such factors as the primacy of a clear clinical diagnosis in suspected epilepsy, the nature of the EEG report being usually suggestive rather than indicative, and the superiority of other investigations (e.g. neuroimaging) in certain situations. The EEG test remains important in the differential diagnosis of both possible cerebral dysfunction (encephalopathy) and seizures, as well as the monitoring of epilepsy. In order to keep the rate of uninformative tests to a minimum, clinicians should carefully describe the presenting signs and symptoms, considering whether these are consistent with epilepsy and whether other investigations are preferable. This information should be included in the EEG referral to improve the utility of the subsequent report.

FENTON, G.W. & STANDAGE, K. (1993) Clinical electroencepahalography in a psychiatric service. *Canadian Journal of Psychiatry*, **38**, 333–338.

STONE, S. & MORAN, G. (2003) The utility of EEG in psychiatry and aggression. *Psychiatric Bulletin*, **27**, 171–172.

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The Bournewood gap is not as wide as it sometimes seems

In response to Singhal *et al* (*Psychiatric Bulletin*, January 2008, **32**, 17–20), I would like to point out a common misunderstanding with regards to the European Court of Justice judgement on the Bournewood case [H.L. *v.* UK, 2005]. The authors give a good description of the case itself, but they then confuse its specifics with the details of the so-called 'Bournewood gap'. This, however, fails to take account of the actual judgement, which concludes that the reason why the court ruled against the Bournewood Trust in that particular case was because of the specific circumstances that amounted to a deprivation of liberty under Article 5 of the Human Rights Act 1998. They listed a number of points regarding complete control over the patient's movements and choices including not allowing visitors and home visits to his carers. It was the completeness of control exercised by the treating team that was the issue at hand rather than the more general point of H.L. lacking capacity to consent to his stay in hospital. The court specifically pointed out that this case should not be considered as a precedent but should be considered on its merits alone. While appreciating that one English judge in particular has given the meaning of *de facto* detention a broader interpretation in his particular judgement, the original European Court of Justice ruling should not be ignored.

When the Ministry of Justice introduced the deprivation of liberty safeguards in the Mental Health Act 2007 (thus amending the Mental Capacity Act 2005) they failed to give any reasonable explanation why the safeguards were necessary. Their official argument that the amendment will bridge the so-called Bournewood gap has to be viewed with some scepticism. This is because the definition of people who fall within the deprivation of liberty safeguards goes much beyond the original case brought to the European Court of Justice. An easier interpretation would have been to use the Mental Capacity Act 2005 to make decisions in the best interests of a patient and thus bridge the Bournewood gap. There was no specific need for additional legislation in this area but it falls in line with a number of local and national decisions taken with anticipatory obedience in order not to fall foul of some perceived legal obligation.

This anticipatory obedience or defensiveness has certainly contributed to giving the Human Rights Act a bad name and the same is potentially possible with the Mental Capacity Act if people get the impression that they have to do unreasonable and additional paperwork in order to comply with the Act. Acting in anticipatory obedience therefore has negative consequences for the perception of perfectly reasonable legislation on top of creating a lot of additional administrative work and costs for the respective authorities who are charged with the execution of the new amendments. As clinicians we ought to contribute to a sensitive interpretation of the new legislation and prevent a situation where staff on the ground consider far too many people to be in danger of potential Human Rights Act breaches.

H. L. v. UK [2005] ECHR.

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Blood-borne virus testing and Hepatitis B immunisation in specialist alcohol and drugs service

In the UK, which has among the highest rates of recorded illegal substance misuse in the Western world, 34% of people diagnosed with Hepatitis B, over 90% diagnosed with Hepatitis C and 5.6% diagnosed with HIV were associated with injecting drug use.

In our cross-sectional survey on 150 individuals under active management by the Trust Alcohol and Drug Services based at Great Yarmouth, 3% were diagnosed positive for Hepatitis B, 19% for Hepatitis C and 2% for HIV. About half had no documentation regarding blood-borne viruses; 36 had at least one dose of Hepatitis B vaccine, but only 18 had three doses. Those who showed a trend towards completing Hepatitis B immunisation were in the age group above 30 years old, known to the services for more than 2 years, injectors, those who accepted the offer of immunisation and those positive for Hepatitis C. This is of concern as studies show an emergence of increasing incidence of blood-borne viruses among new, young and vulnerable drug users.

At the time of our study, 22% individuals shared injecting equipment. Injecting is not only a key factor in the transmission of blood-borne viruses, but also plays a significant role in deaths from overdose, accounting for more than 7% of all the deaths among those aged 15–39 years old in 2004 (European Monitoring Centre for Drugs and Drug Addiction, 2006).

We recommend the following: (1) clinicians need to collect, keep, analyse and make effective use of patient data including sexual health and injecting practice; (2) drug and alcohol services should increase awareness of harm from injecting drug use, with particular regard to blood-borne viruses and overdose; and (3) effective treatment goals should include testing, immunisation and treating of blood-borne viruses for all service users.

EUROPEAN MONITORING CENTRE FOR DRUGS AND DRUG ADDICTION (2006) *Drug-Related Infectious Diseases and Drug-Related Deaths. Annual Report. The State of the Drug Problem in Europe.* European Monitoring Centre for Drugs and Drug Addiction (http://www.emcdda.europa.eu/html.cfm/index41529EN.html).

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