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The case for the long case

Having taken (F.O.) the Objective Structured Clinical Examination (OSCE) as part of the MRCPsych part I, I found that the skills acquired for the exam were less helpful in my day-to-day clinical work than presentations of cases to senior colleagues. These allowed me to have a more comprehensive grasp of the scenarios. Plans to jettison the long case will lead to a reduction in emphasis on one's ability to perform such presentations (Oyebode *et al*, 2007).

Moreover, as a trainee for whom English is a second language I fear that replacing the long case with objective structured examination will deprive people like me of the opportunity to improve our language skills.

Thus we support the case for the long case!

OYEBODE, F., GEORGE, S., MATH, V., *et al* (2007) Inter-examiner reliability of the clinical parts of MRCPsych part II examinations. *Psychiatric Bulletin*, **31**, 342–344.

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Vending machines in acute psychiatric units: what purpose do they serve?

People with mental illness are over 50% more likely to be overweight or obese

than those without (Compton *et al*, 2006). Evidence shows that people with schizophrenia have an increased risk of early death, mostly due to cardiovascular disease and diabetes linked to obesity.

A case-control study carried out in Nithsdale, Scotland (McCreadie *et al*, 1998) showed that most patients with schizophrenia were overweight or obese and their intake of saturated fats was higher compared with age-matched controls. On average they consumed 12 portions of fruit and vegetables a week instead of the recommended 35 per week. It was concluded that people with schizophrenia were making poor dietary choices and assertive programmes were needed.

Patients admitted during acute phase of their mental illness often have impaired judgement; therefore care should be anything but increased in such situations. However, astonishingly many mental health units have placed vending machines outside the acute mental health wards, which only dispense chocolate bars, crisps and soft drinks, with no healthy options. It is hard not to be cynical about the motives behind installation of such machines; surely it is not just for the convenience of patients. Instead of being opportunistic, offering patients a diet rich in calories, refined starch and fat at their doorstep can in no way be justified.

Since stimulus control is an integral part of weight management, it is time to put the practice right and make healthier choices available to the already vulnerable client group. As healthcare professionals we cannot justify waiting for someone like Jamie Oliver to teach us the basic rules of a balanced diet.

COMPTON, M. T., DAUMIT, G. L. & DRUSS, B. G. (2006) Cigarette smoking and overweight/obesity among individuals with serious mental illnesses: A preventive perspective. *Harvard Review of Psychiatry*, **14**, 212–222.

MCCREADIE, R., MACDONALD, E., BLACKLOCK, C., *et al* (1998) Dietary intake of schizophrenic patients in Nithsdale, Scotland: case-control study. *BMJ*, **317**, 784–785.

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MTAS fiasco: further shortlisting issues

Before the review group set up by the Department of Health (March 2007) to assess the Medical Training Application Service (MTAS) allowed for guaranteed interviews with trainees, a north London psychiatry rotation was surveyed regarding their MTAS experiences in a similar method to that of Whelan *et al* (2007).

Of the 52 trainees approached about the survey, 37 responded (71%). Of those, 32 were shortlisted (86%) by MTAS, 18 were offered one interview (49%), 8 two interviews (21%), and 3 were offered three or four interviews (8%). The ratio of applications to interviews was 2.3:1.

This group, which had been competitively selected in the past 2 or 3 years for basic psychiatric training in a popular London rotation, did better than the Whelan's sample (60%) in succeeding in being shortlisted at all. However, 19 of these London trainees (51%) were not shortlisted by MTAS for London. Conversely, 12 (66%) of the remaining 18 trainees that were shortlisted for London (an area generally assumed to be competitive) were not shortlisted elsewhere.

As regards applicants with Highly Skilled Migrant Permits, forming 3% of the total sample, 20% were not shortlisted, compared with 4 out of the total 31 (13%) with UK/EEA/Spousal visas.

Trainees' comments attest to the emotion behind the numbers:

'The lottery-like [shortlisting] result... illustrates the absurdity of this process.'

'I think it's not so much the system as the loss of 8000 jobs that is appalling.'

'Why should doctors with families... have to consider "less competitive geographies"... especially as we have been appointed in open competition in the old system?'

Like Whelan's, this survey highlighted the questionable validity and reliability of the initial MTAS shortlisting process.

WHELAN, P., JARRETT, P., MEERTEN, M., *et al* (2007) MTAS fiasco: lessons for psychiatry. *Psychiatric Bulletin*, **31**, 425–427.

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