the columns

correspondence

In defence of the long case

Benning & Broadhurst (*Psychiatric Bulletin*, December 2007, **31**, 441–442) argued that the abandonment of the long case from the Member of the Royal College of Psychiatrists (MRCPsych) exam threatens the holistic approach in psychiatry and ignores the importance of the subjective dimension of the experience/behaviour and the role of the patient's biography in aiding understanding. We share their concern.

An online survey of trainee psychiatrists working in the North Trent Rotation Scheme with a response rate of 46% (n=43; ST1–3 and trust grade doctors n=26, ST4 and specialist registrars n=17) showed that the majority of trainees (62.8%) did not agree with abandoning the long case. Those who have passed the MRCPsych (i.e. ST4 grade and specialist registrars) opposed it more strongly than junior trainees (94% *v.* 42%, P=0.01). Similarly, senior trainees were more likely to disagree that Observed Standardised Clinical Examination (OSCE) is a fair alternative than junior trainees (76.5% *v.* 34.6%, P=0.01), but is not capable of testing from the bio-psychosocial perspective (82% *v.* 50%, P=0.05). Unsurprisingly, more senior trainees (58.8%) than junior trainees (30.8%) felt that the exam would be easier.

The majority of responders were concerned that passing the long case depends largely on one encounter. This could be addressed by incorporating one or two long cases per year as part of workplace-based assessments, which would ensure the appropriate choice of patients and possibly more time allocated for each case, as it has been shown to increase reliability from 0.60 to 0.90 (Waas & Jolly, 2001).

Finally, although we agree that OSCE could test different specific competencies, we should not forget that 'the whole is more than the sum of its parts' as one of our responders commented.

WASS, V. & JOLLY, B. (2001) Does observation add to the validity of the long case? *Medical Education*, **35**, 729–734.

Lekshmi Premkumar ST1 Doctor in Psychiatry, Sheffield CareTrust, ***Mohammed Abbas** Specialist Registrar in Psychiatry, Rotherham General Hospital, Mental Health Unit, Moorgate Road, Rotherham S60 2UD, email: mohdgum@hotmail.com

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How and why the long case should be kept: a view from the antipodes

The commentary by Tyrer (*Psychiatric Bulletin*, December 2007, **31**, 447–449) summarises the reasons why the Royal College of Psychiatrists has decided to abandon the long case as a summative assessment in the MRCPsych examination. The Royal Australian and New Zealand College of Psychiatrists, however, continues to have a long case in their exams for Fellowship as well as OSCEs. The form of the long case is a 50-minute interview by the candidate who is observed by two examiners. After the interview the candidate has 20 minutes to produce a formulation and management plan, which they then discuss with the examiners.

We have persisted with the long case because it is a valid test of important skills. The most important skill it tests is the ability to prioritise information and 'make sense of a case' – the time limits force the candidates to work out what are the key issues for the patient. The long case gives trainees and supervisors an important message that interviewing and formulation are skills fundamental to the practice of psychiatry and it also provides an incentive for supervisors to observe their trainees' interview.

We ensure the reliability of the long case through a number of measures. Each candidate is examined by a senior and experienced examination committee member and an invited co-examiner. Prior to the exam all examiners have a 3-hour training workshop to standardise their marking. During the viva part, examiners may only ask candidates questions from a limited menu of clarification probes. Examiners initially mark the candidate independently and then agree on a consensus mark on five domains using a 5-point scale – half of the marks awarded are identical, a further 40% are discrepant by only one grade, and less than 10% are discrepant by more than one grade. The discrepant marks are resolved by consensus between the examining pair and if this is not possible, each discrepant mark can be discussed at an examiners' meeting at the end of the examination. While the patients may be different, what the examiners look to mark in candidate performance is generalised and standardised.

There are also important negative reasons why we have decided to keep the long case as a summative assessment in the Fellow of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP) examination. We agree with Tyrer that the main question is not whether the skills tested in a long case are important and need to be assessed, but whether they need to be assessed using a summative examination. A major value of a summative assessment is that the examiners have no possible conflict of interest or even awareness of the prior training and examination history of the candidate. Making the long case part of training as a formative assessment does not get around any problems of reliability and may make the reliability worse as assessors do not have the same degree of examination training. There may also be a significant conflict of interest with local supervisors keen to get their trainees through training.

Finally, there is the wider issue of the change in culture in medicine. Increasingly there are moves to reduce medicine to a set of procedures which are laid out by guidelines, encouraged by incentive payments and evaluated by audit or other performance measures. Relying solely on OSCEs encourages this tick-box procedural approach to healthcare. We believe that what patients need when they visit a specialist is someone who can make sense of complexity, knows what procedures to use and what to do when they do not work. Dropping the long case in the examination is not good for consumers and risks reducing psychiatry to a set of simplistic procedures.

***Simon Hatcher** Senior Lecturer in Psychiatry, University of Auckland, Auckland Hospital Support Building, Level 12, Private Bag 92019, Auckland, New

columns

Zealand, email: s.hatcher@auckland.ac.nz, **Dennis Handrinos** Consultant Psychiatrist, University of Melbourne, Victoria, Australia, **Kym Jenkins** Consultant Psychiatrist, Department of Psychiatry, Alfred Hospital, Melbourne, Victoria, Australia

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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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Lena Palaniyappan Academic Clinical Fellow, Division of Psychiatry, Institute of Neuroscience, Newcastle University, Leazes Wing, Royal Victoria Infirmary, Newcastle upon Tyne NE1 4LP, email: Lena.Palaniyappan@newcastle.ac.uk

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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).

Jon van Niekerk Specialist Registrar in General Adult Psychiatry, Rawnsley Building, Manchester Royal Infirmary, Oxford Road, Manchester M13 9WL, email: vzvanniekerk@hotmail.com

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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 $\geqslant 65$ 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 $\geqslant 65$ 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 $\geqslant 65$ 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