Correspondence

Friday the 13th and fatal self-harm

Sir: The belief that Friday the 13th is unlucky for some is entrenched in our language and has been held throughout history in many cultures. Scanlon *et al* (1993) reported that the risk of hospital admissions as a result of a transport accident may be increased by as much as 52% on Friday the 13th. They recommended staying at home.

Superstitiousness correlates significantly with some aspects of compulsive behaviour and obsessional ruminations (Veale, 1995), and superstitious people see causal relationships between their own thoughts or actions and events in the world. Superstitions, such as unlucky Friday the 13th, may affect our behaviour and tend to flourish whenever we cannot tolerate uncertainty or believe that we have no control over events. The presence or absence of an association between events such as suicide and Friday the 13th does not appear to have been reported previously.

Between 1989 and 1995 there were 364 Fridays, 84 13th days of the month and 12 were Friday the 13th. A total of 277 incidents of fatal self-harm (FSH) were reported within North Cheshire. (The term FSH is used here to describe all coroners' verdicts of suicide, misadventure and open verdict.) Fifty FSH incidents were reported on all Fridays (13.7%), 10 on the 13th days (11.9%), one incident on Friday the 13th and one on Friday the 6th (8.3%). There is no statistically significant difference between proportions (χ^2: d.f.=3, $P>0.05$) indicating that FSH is equally likely to occur on Friday the 13th as on Friday the 6th (the day chosen by Scanlon *et al*, 1993 for comparison), as well as on any Friday and any 13th day. Based on the small numbers available for this review, the probability of an incident of FSH occurring or being reported on Friday the 13th or Friday the 6th was 0.004 (one incident in 277), identical to the proportion of either Friday 13th or 6th in the seven years of data collection (12 days in 2555). This means that FSH reported in North Cheshire on Friday the 13th probably occurred by chance alone and provides no evidence of any increased or reduced risk on this particular day. There was also no observed pattern on the day before or after Friday the 13th. Mean psychiatric admissions did not differ significantly on those days except for a generally reduced rate of hospital admissions on the 13th day over the same period.

All days are certainly unlucky days for those who succeed in harming themselves fatally, deliberately or otherwise, and for the unfortunate people they leave behind. However, Friday the 13th appears to have been neither chosen nor avoided.

SCANLON, T. J., LUBEN, R. N., SCANLON, F. L., *et al* (1993) Is Friday the 13th bad for your health? *British Medical Journal*, **307**, 1584–1586.

VEALE, D. (1995) Friday the 13th and obsessive compulsive disorder. *British Medical Journal*, **311**, 863–864.

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Objective structured clinical examination

Sir: The Nottingham report on objective structured clinical examination (OSCE) (*Psychiatric Bulletin*, January 1997, **21**, 30–32) fuels interest in undergraduate assessment methods and is a veritable response to the General Medical Council's call for innovativeness in course objectives and structuring. However, the traditional long case (TLC) has more demerits than was portrayed. It is true that the TLC presents opportunity for assessing interactional skills, and a candidate can rectify an error made earlier in the examination. But in real life practice some avoidable errors cannot be rectified.

From our modest experience, we believe that surreptitiously set OSCE stations could test interpersonal skills to an acceptable degree. We should furthermore emphasise that fairness, objectivity (minimal examiner's bias), an ingredient of validity, wide coverage of the course and economy of examining time are the unique virtues of the OSCE.

Comparability of examination methods is difficult, especially with variability of settings and instructional objectives (Petrusa *et al*, 1986); however, a holistic examination package which retains the TLC in an attenuated form offers bright prospects of meaningful assessment of students.

PETRUSA, E. R., BLACKWELL, T. A., PARCEL, S. L., *et al* (1986) Psychometric properties of the objective clinical examination (OSCE) as an instrument for final evaluation. In *Newer Developments in Assessing Clinical Competence* (eds I. R. Hart, R. M. Harden &

J. H. J. Walton), pp. 181–191. Montreal: Heol Publications.

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Psychotherapy experience for trainees

Sir: Debate within the College has suggested that compulsory psychotherapy experience for psychiatric trainees would lead to an erosion of opportunity for research experience. Published research is widely seen as a prerequisite for progression through the training grades (Duffet, 1994), yet concern has been raised as to whether it is feasible for trainees to pursue meaningful research before moving into the specialist registrar/senior registrar grade (Timini, 1995). It may be that trainees involved in research are doing so at the expense of psychotherapy training or vice versa. An alternative, but perhaps less charitable, viewpoint is that while some trainees are keen to do both research and psychotherapy, others consistently manage to avoid doing both.

To investigate this further we conducted a questionnaire survey of psychiatric trainees at registrar level training with the South Thames (West) training scheme based at St George's Hospital, Tooting, South London. All registrars training in psychiatry in the Region in 1995–1996 received a two-part questionnaire. The first part focused on how many psychotherapy cases the trainee had treated, subdivided into modalities including cognitive–behavioural and individual psychodynamic psychotherapy. The second part of the questionnaire asked about the number and type of research projects the trainee was involved in.

Fifty-four questionnaires were received from 56 trainees giving a response rate of 96%. Direct involvement in research activity was claimed by 79% of the sample; 93% had treated one or more cognitive–behavioural cases, while 85% had treated one or more individual psychodynamic cases. Kendall's tau correlation coefficients showed no association between number of research projects and number of individual psychodynamic cases treated (τ=0.092, P=0.404). There was, however, a significant correlation between number of research projects and number of behavioural cases treated (τ=0.336, P=0.003).

These findings do not support the idea that trainees who make time for treating psychotherapy cases do so at the expense of research involvement. Trainees treating cognitive–behavioural psychotherapy cases appear able to combine activity in both and should continue to be encouraged to do so.

DUFFET, R. (1994) Publication by junior doctors: why do they do it? *Psychiatric Bulletin*, **18**, 553–554.
TIMIMI, S. (1995) Trainee psychiatrists' theoretical vacuum (letter). *Psychiatric Bulletin*, **19**, 707.

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Evidence-based medicine

Sir: I read with interest Schmidt *et al*'s editorial on evidence-based medicine (EBM) (*Psychiatric Bulletin*, December 1996, **20**, 705–707). I would like to add a few pertinent details from Sacket *et al* (1996) (also listed in Schmidt *et al*'s article).

Sacket (Director of NHS Research & Development Centre for EBM, Oxford, UK) and co-workers use a comprehensive definition of EBM: ". . . the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients". Its practice ". . . means integrating individual clinical expertise with the best available external evidence from systematic research". If there is no available evidence that fulfils gold standards, then ". . . we follow the trail to the next best external evidence and work from there".

Schmidt *et al* depict a scenario where insisting on the best option may augment a patient's resistance to treatment or affect the doctor–patient relationship. A clinical decision process must include the patient's relative preferences (i.e. utilities), or better still, the values that the patient assigns to such utilities. Only when a patient cannot do this might the clinician alone quantify these utilities. In either situation, the final decision may not necessarily favour the option best supported by the external evidence. Thus, Sacket *et al* argue that external clinical evidence ". . . can never replace individual clinical expertise and it is this expertise that decides whether the external evidence applies to the individual patient at all, and, if so, how it should be integrated into a clinical decision"; that is, EBM strengthens but does not supplant clinical expertise.

Schmidt *et al*'s assumption that many will feel unable to appraise research articles critically is not a strong argument to dismiss EBM. For many it may take some practice to become proficient, but the same applies to the development of most other skills.