columns

but I would suggest that they have less relevance to audit and appraisal than research. Indeed, it is all too often forgotten that clinical audit uses standard research methods and will generate unreliable results unless carefully designed (Lawrie & Sandercock, 2004).

One of the main problems with the higher trainees research day as it currently operates is that it is often inadequately organised and supervised. Most trainees would gain a lot more from a 4- or 6-month slot in full-time research as part of a research group, and this would constitute only a ninth or a sixth of a 3-year training programme. Such attachments could be allocated to those who requested them, as other training posts are at present. Overall, this would probably increase the numbers of psychiatrists with research skills; this would be important not only for audit but also for the promotion of research of direct clinical relevance. If our practice is to be influenced by more than politics and fashion, we need more research in psychiatry rather than less.

LAWRIE, S. M., SANDERCOCK, P. (2004) Epidemiology and research methods. In *Companion to Psychiatric Studies* (7th edn) (eds E. C. Johnstone, D. G. C. Owens, S. M. Lawrie, *et al*) pp. 65–184. Edinburgh: Churchill Livingstone.

Stephen M. Lawrie Sackler Senior Clinical Research Fellow, Royal Edinburgh Hospital, Edinburgh EH10 5HF

Research for the sake of research

I wholeheartedly agree with the views expressed by Nicola Phillips in her letter 'Who wants to be a specialist registrar?' (*Psychiatric Bulletin*, March 2005, **29**, 115). One of the biggest worries one has when applying for specialist registrar posts is the absence of research experience on one's CV.

Research is clearly very important for the advancement of psychiatry or for any other specialty for that matter. It is also important that trainees be encouraged to do research work. But does every single trainee have to do research work? Not everybody has the same aptitudes and interests; research for the sake of research is not very helpful. Some trainees are more interested in being good clinicians or have other special interests. For example, a special interest in psychotherapy should be given the same weight age as one in research.

It is also time to consider the research day that all registrars are given. It might not be the most effective use of time for someone who is not interested in research. As much as science needs good research, patients need good clinicians and psychiatry needs professionals with different interests.

Pavan Chahl Staff Grade in General Adult Psychiatry, Hellesdon Hospital, Norwich

A case for the 4-month SHO post?

With Part II of the MRCPsych examination rapidly approaching, I wonder how far the College has gone in considering reducing the length of training posts to 4 months from the current 6.

Several medical rotations have already embraced this approach in order to provide breadth of training within the limited time available. There seem to be several reasons why this approach might also be suited to psychiatry.

First, having completed the required posts for examination entry, including 6 months in neurology, I am soon to enter my 4th year as a senior house officer (SHO) and would still benefit from experience in forensic, psychiatric intensive treatment unit, perinatal and specialist addiction service roles. Four-month posts would allow all of this experience to be gained within 3 years, and allow time to be spent in research prior to entry into higher specialist training.

Second, competitive posts along with those required for examination entry can at times be in short supply and there will be a continued need for suitable placements to be found for general practitioner trainees, pre-registration house officers in their 2nd foundation year and perhaps in the future SHOs in medicine/neurology. Shorter posts should reconcile some of these competing demands if staffed appropriately while at the same time: (a) increasing exposure to psychiatry among other medical professionals, and access to medicine/neurology among psychiatric trainees; (b) decreasing stigma via familiarity; (c) facilitating recruitment; and (d) reducing some of the historical barriers between psychiatry and the rest of medicine that seem so much of an anachronism today.

Brent Elliott Senior House Officer, A & E Liaison and Crisis Intervention Service, Royal London Hospital, Whitechapel E1 1BB, e-mail: brentelliot@aol.com

Moving consultant post

Dr Smithies writes about her experience in moving consultant post (*Psychiatric Bulletin*, February 2005, **29**, 65–66). We compared the characteristics of consultants who remained in post (stills) with those who moved to a new post (movers) using two surveys of workload and stress in consultant old age psychiatrists (Jolley & Benbow, 1997; Benbow & Jolley, 2002). Of those who contributed to both surveys, one-quarter changed post over 4 years. Movers did not differ significantly from stills in relation to age, gender, marital status or work pattern. Individual doctors described similar stress levels in both surveys, suggesting that stress profiles remain stable. Movers were slightly younger than stills, and more often came from small teams, rather than working alone or in a larger team (but these findings were not statistically significant). Measures of stress in the second survey did not differentiate between the groups.

The mobility of consultant psychiatrists is an important feature of National Health Service practice. Moving is not, however, associated with an abnormal stress profile, or a change in an individual's perceived level of stress.

A mobile workforce brings with it advantages and disadvantages. Bringing new ideas and approaches from one culture to another is enlivening and stimulating. It avoids the risk of staff losing enthusiasm through boredom and sameness. For patients and carers, it reduces the risk that institutionalisation will mask, conceal, excuse or condone poor or exploitative behaviour. However, too much change can be counterproductive: promoting uncertainty and undermining confidence, and reducing the efficiency derived from established interpersonal links.

BENBOW, S. M. & JOLLEY, D. J. (2002) Burnout and stress among old age psychiatrists. *International Journal of Geriatric Psychiatry*, **17**, 710–714.

JOLLEY, D. J. & BENBOW, S. M. (1997) The everyday work of geriatric psychiatrists. *International Journal of Geriatric Psychiatry*, **12**, 109–113.

***Susan M. Benbow** Consultant Old Age Psychiatrist, Wolverhampton City Primary Care Trust and Professor of Mental Health and Ageing, Wolverhampton University, West Midlands WV4 5HN, e-mail: susan. benbow@wlv.ac.uk, **David J. Jolley** Director of Dementia Plus West Midlands, Wolverhampton

The objective structured clinical examination

The case for and against the objective structured clinical examination (OSCE) has generated many interesting letters in the *Bulletin* recently. The unequivocal and emphatic response by Mortimer & Lunn (*Psychiatric Bulletin*, December 2004, **28**, 458) is welcome. It is clearly 'here to stay' (apology unnecessary, in my opinion).

The pros – examination of a broad range of scenarios, reducing the luck factor – outweigh, I feel, concerns about limited time and the fostering of 'fast psychiatry' (Yak *et al*, *Psychiatric Bulletin*, July 2004, **28**, 265–266). It is a useful addition to the examination format. However, concerns about the challenge of handling the long case format deserve a response.

https://doi.org/10.1192/pb.29.6.232-c Published online by Cambridge University Press

columns

The ability to deal with long cases should be a fundamental skill acquired during one's training. Surely it is never too early to acquire this skill when embarking on a career in psychiatry. We all recognise that examinations provide a major (for some essential) incentive to learn. Therefore, unlike Narula (*Psychiatric Bulletin*, February 2005, **29**, 72–73), rather than review the long case format in the Part II examination, I would advocate the use of both the OSCE and long case formats for both parts of the examination. Obviously, this would lead to some logistical problems but would the College fear being accused of placing too much emphasis on clinical acumen?

MacDara McCauley Senior Registrar, St Davnet's Hospital, County Monaghan

Thiamine treatment of Wernicke–Korsakoff syndrome in alcoholism

I was delighted to read the article by McIntosh *et al* (*Psychiatric Bulletin*, March 2005, **29**, 94–97) encouraging the use of parenteral thiamine for the early treatment of Wernicke–Korsakoff syndrome in alcoholism. Such treatment greatly improves outcome in some alcoholics (Guthrie & Elliott, 1980; Macdonald, 1994).

However the *British National Formulary* recommends one pair of high-potency ampoules twice daily for 7 days, so the guidelines given fall short of an adequate dose. Also, it is hard to detect any useful clinical response within 2 days; my own experience is that 3–4 weeks are required before improvement in memory function can be detected.

GUTHRIE, A. & ELLIOTT, W. A. (1980) The nature and reversibility of cerebral impairment in alcoholism: treatment implications. *Journal of Studies on Alcohol*, **41**, 147–155.

MACDONALD, A. J. (1994) A paper that changed my practice: reversible mental impairment in alcoholics. *BMJ*, **308**, 1678

Alasdair Macdonald Consultant Psychiatrist, North Dorset Primary Care Trust, Forston Clinic, Dorchester DT2 9TB

Neuroimaging in dementia

We agree with Dr Fielding that neuroimaging in dementia is controversial (*Psychiatric Bulletin*, January 2005, **29**, 21–23). Guidelines vary between the relatively restrictive Royal College of Psychiatrists (1995) statement, referred to by Fielding, to the all-inclusive consensus statement from the American Academy of Neurology (2001) in which computed tomography/magnetic resonance imaging (CT/MRI) is recommended.

We conducted a small audit which has some similar findings to those of Fielding. Out of 32 patients scanned in the past year whose notes were readily accessible, 25 (79%) were referred for CT scan according to College guidelines. Only 1 (3%) potentially reversible cause of dementia was found: an incidental meningioma which was not treated. This rate compares closely with Fielding's report. We also found a very high prevalence of cerebrovascular disease: ischaemic changes or infarcts being found in 27 patients (85%). This prevalence is much higher than in Fielding's report, perhaps reflecting variation in radiological reporting and/or geographical variation in the prevalence of this disorder.

The very low incidence of potentially reversible causes may reflect the patient group presenting to old age psychiatry. This may be higher in neurology clinics and other settings. The high prevalence of cerebrovascular disease is perhaps of much greater clinical significance to the old age psychiatrist. There may be treatment implications arising from an emerging view that vascular and Alzheimer pathology co-exist (Langa *et al*, 2004), and this might be justification for CT as a routine test, as advocated by the draft Scottish Intercollegiate Guideline Network (SIGN).

KNOPMAN, D. S., DEKOSKY, S. T., CUMMINGS, J. L., *et al* (2001) Practice parameter: Diagnosis of dementia (an evidence-based review). Report of the Quality Standard Sub-Committee of the American Academy of Neurology. *Neurology*, **56**, 1143–1153.

LANGA, K. M., FOSTER, N. L. & LARSON, E. B. (2004) Mixed dementia. Emerging concepts and therapeutic implications. *Journal of the American Medical Association*, **292**, 2901–2908.

ROYAL COLLEGE OF PSYCHIATRISTS (1995) *Consensus Statement on the Assessment of an Elderly Person with Suspected Cognitive Impairment by a Specialist Old Age Psychiatry Service* (Council Report CR49). London: Royal College of Psychiatrists.

Michael Hughes Final Year Medical Student, ***Tom MacEwan** Consultant Psychiatrist, Old Age Psychiatry Directorate, Konord, Royal Cornhill Hospital, Cornhill Road, Aberdeen AB25 2ZH

https://doi.org/10.1192/pb.29.6.232-c Published online by Cambridge University Press