the columns

correspondence

Part I OSCE examinations

We would like to respond to Yak *et al* regarding their reservations about the objective structured clinical examination (OSCE) in Part I of the Membership Examination (*Psychiatric Bulletin*, July 2004, **28**, 265–266).

The College OSCE has not been borrowed from any other college's examination. We have, however, learned from others' experiences, both at undergraduate and postgraduate level. OSCEs have been used for clinical assessment for 30 years and there is a considerable body of evidence to support their validity. In psychiatry, most of the evidence in postgraduates has come from abroad, particularly from the Wilson Centre for Research in Education, University of Toronto, Canada (Hodges *et al*, 1998). The case for modernising the college examinations was ably put by the current and previous Chief Examiners (Tyrer & Oyebode, 2004).

The constructs of the individual OSCE stations are not 'difficult and complex investigations' leading to 'snap diagnosis'. They are designed around focused tasks within common clinical work, in which candidates should be able to demonstrate a basic competency within the allotted time after a year of SHO training. All OSCE stations are extensively piloted and edited to make sure that they work, before being launched at a Part I examination, and remain subject to review and refinement.

There is no intention to encourage 'quick perfunctory examination of patients', but to ensure that candidates possess the relevant clinical skills that the constructs elicit; this necessitates accurate, focused clinical thinking and effective interviewing of patients. We are also now able to focus on essential skills not previously tested, such as communication with patients, carers and a variety of professional groups, physical examination and not least psychopathological examination in a 'standardised' clinical scenario.

The College retains an examination that involves the whole person appraisal recommended by Yak *et al*. This rightly belongs in Part II of the examination. After at least another 2 years' training, candidates are expected to produce a sophisticated diagnosis and formulation based on a comprehensive assessment as well as discuss patient management.

Sorry, but Part I OSCEs are here to stay!

Perhaps an important point to be made is that rotating around 12 OSCE stations removes the elements of good or bad luck and patient variability, which make long case examinations so capricious, leaving aside the opportunity to shine in at least some areas rather than putting all one's eggs in one basket.

HODGES, B., REGEHR, G., HANSON, M., *et al* (1998) Validation of an objective structured clinical examination in psychiatry. *Academic Medicine*, **73**, 910–912.

TYRER, S., OYEBODE, F. (2004) Why does the MRCPsych examination need to change? *British Journal of Psychiatry*, **184**, 197–199.

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Copies of letters to GP sent to patients

Recent articles in the *Bulletin* suggest that there may be growing support for this, both from within the profession and from patients (Lloyd, *Psychiatric Bulletin*, February 2004, **28**, 57–59). Survey data have sometimes been based on attitudes towards a practice they had not yet been exposed to (Dale *et al*, *Psychiatric Bulletin*, June 2004, **28**, 199–200), which may at least partially explain respondents' relatively low preference for the psychiatrist's GP 'usual letter', opting more often for a 'separate simple' letter, which these authors saw would also safeguard 'the professionalism of medical communication'. Patients' mental capacity to understand information and respond to it appropriately were considered important issues, so extending the practice to child and adolescent psychiatry might be expected to prove problematic.

In fact, I found that this proved not to be difficult over the course of a recent 12-month locum post. Concerned that I was undertaking locum consultant responsibility on a part-time basis, in a region distant from my own home where no other psychiatrist specialist was in post, but unaware of the NHS Plan (2000) that all patients should receive such correspondence by April 2004, I decided to copy all my correspondence with GPs to patients and their patients, simply on the basis that such transparency might help facilitate continuity of care in my absence. My patients varied in age from 5 to 16, and in over 70 cases there were only two instances when problems arose. I decided against sending one letter as I considered one mother's well-being to be too fragile to tolerate it; for another family, the detailed summary of relevant history proved an overwhelming read.

Patients and their parents were otherwise uniformly appreciative. I also discovered that when I sometimes sent out a completed letter, aware that I had been unable to reduce a complex issue sufficiently for the child to readily understand (and thus decide whether they agreed with it), their parent between sessions had done so – sometimes in inspiring ways. I never sent patients 'separate, simple' letters. Instead they got the 'usual' letter, but one that always took me a bit longer to write as I had recognised the challenge Lloyd & Roy (*Psychiatric Bulletin*, January 2004, **28**, 33–35) have described. And Roy was right: the challenge in child and adolescent psychiatry is far from insurmountable. But the 'usual' letter must reach a high standard.

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Partners in care and partners in training

After trudging through the somewhat dry and sterile land of textbooks and evidence-based literature in preparation for the MRCPsych Part II examination, it was both refreshing and enlightening to read the special articles (Partners in care) published in September 2004 in the *Psychiatric Bulletin*.

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