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.

A. M. Mortimer Deputy Chief Examiner with responsibility for Part I, Royal College of Psychiatrists, **Brian Lunn** Senior Lecturer in Psychiatry and Chair, OSCE Panel

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.

R. M. Wrate 49 Morningside Park, Edinburgh EH10 5EZ

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*.

https://doi.org/10.1192/pb.28.12.458-b Published online by Cambridge University Press

columns

Just as literature can be used as a means of understanding the inner life of others as well as ourselves (Oyebode, *Psychiatric Bulletin*, April 2002, **26**, 121–122), articles such as these autobiographical narratives deepen our understanding of individual experiences, and facilitate our engagement of patients and carers on a more intimate level. The Department of Health (2001) has emphasised the importance of user and carer involvement in mental health services at a variety of levels e.g. service delivery, training and research. Some may be sceptical of user involvement (Tyrer, *Psychiatric Bulletin*, October 2002, **26**, 406–407), but I am looking forward to my higher specialist training as patients and carers become involved in enriching the learning experience of all psychiatrists.

DEPARTMENT OF HEALTH (2001) *Involving Patients and the Public in Healthcare: A Discussion Document*. London: Department of Health.

Nicole Karen Fung SHO in Psychiatry, Queen Elizabeth Psychiatric Hospital, Edgbaston, Birmingham B15 2QZ

Malignant Alienation – a concept that has not yet arrived?

I read with interest the article by Graham *et al* regarding addressing carer attitude to difficult patients (*Psychiatric Bulletin*, July 2004, **28**, 254–256). The uptake of new concepts like malignant alienation into mainstream teaching and practice depends on a number of factors, including usefulness and comprehensibility. We described malignant alienation in detail a decade ago (Watts & Morgan, 1994). Strategies were documented for preventing and managing the alienation process for difficult patients on psychiatric wards with the specific aim of reducing inpatient suicide. However, despite knowing much about the nature of inpatient suicide, malignant alienation is not found in the latest editions of any of the leading standard UK postgraduate textbooks.

My own recent small postal survey of consultant psychiatrists in one teaching area (16 surveyed, 12 responded) found that more than half knew it was not taught to their trainees and a third felt it had not informed their own practice. It seems that the concept is not taught widely and is applied patchily, but why? Malignant alienation is acknowledged as a useful concept from forensic units (Torpy, 1994, personal communication) through to learning disability. The weight of its psychological components may have led to a slower uptake within units where a biomedical approach is prevalent, and this explanation is reinforced from my own survey which suggested the presence/absence of a consultant psychotherapist (or similar champion) was pivotal in psychological concepts gaining credibility or not. Or perhaps avoidance of the powerful negative feelings at the heart of the alienation process itself still continues to explain its omission from standard teaching?

WATTS, D. & MORGAN, G. (1994) Malignant alienation: dangers for patients who are hard to like. *British Journal of Psychiatry*, **164**, 11–15.

Darryl Watts Handley Cross House, Harewood End, Herefordshire HR2 8JT

The nuts and bolts of repatriating patients

We read with interest the review article by Gordon *et al* (*Psychiatric Bulletin*, August 2004, **28**, 295–297) on air travel by passengers with mental disorder. We would like to share our experience of the difficulties in assessing a patient and the process involved in repatriation.

Our patient was from an Eastern European country, which recently became a member of the European Union. She was admitted with a history of aggression and bizarre behaviour. Gordon *et al* emphasise that assessment of fitness to travel is essential. However, this can prove to be difficult in individuals who do not speak English as the understanding and interpretation of symptoms in psychiatry is not consistent across languages. In spite of efforts to assess our patient through an interpreter, we were not entirely sure of the psychopathology, diagnosis and risks involved. Our working diagnosis was of one of a psychotic disorder, she was treated with neuroleptics. There was limited improvement.

The patient persistently asked to be repatriated. This left us in a dilemma as to whether we should continue her treatment in the unit or repatriate her. On the one hand, we were uncertain of the services in her country and her suitability for travel, but on the other hand, her persistent request to return home was making her worse. We eventually decided that it was in her best interest to be repatriated. There was a substantial delay between the time when we decided to repatriate and the actual departure. This was due to a number of reasons including: initially the wrong form being requested by the insurance company (E107, which does not exist); lack of communication directly with the insurance company; and uncertainties as to whose responsibility it was to make the travel arrangements and meet the costs.

We found an official from the patient's Consulate in London to be of invaluable aid. They were useful in liaising with the insurance company, identifying the correct form (E111) that authorises expenditure for treatment and repatriation and arranging for someone to meet the staff and the patient at the destination point.

Reports were provided for the insurance company and the airlines. The airlines made us aware that travel arrangements would be more complicated if medication was required during the flight. The travel arrangements were made by the trust management team. Eventually, the patient was repatriated successfully. We were left feeling exhausted, but learned from our ordeal.

***R. Arif** Special Registrar in Psychiatry, Lyndon Clinic, Hobs Meadow, Solihull B92 8PW,
P. C. Naik Consultant Psychiatrist, Lyndon Clinic, Solihull

https://doi.org/10.1192/pb.28.12.458-b Published online by Cambridge University Press