straightforward issue is more complex within the realm of psychiatry, particularly forensic practice. The choice agenda could be seen as a new reincarnation of an old clinical dilemma, that of balancing autonomy with the limitations of freedom accompanying detention under mental health legislation.

What is required is a sophisticated understanding of all the dynamics highlighted here, including clinical, risk and resource issues. It is hoped that such an understanding will allow patients genuine choice in the complex contexts within which they receive care.

**Declaration of interest**

None.

**References**


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**PAMeLA ASHURST**

**On listening to the patient: Commentary on... The long case is dead†**

'May I never see in the patient anything but a fellow creature in pain. May I never consider him merely a vessel of the disease' Maimonides (1135–1204).

I accepted the invitation to comment on the Editorial by Benning & Broadhurst (2007, this issue) with some trepidation. Since retiring from the NHS in 1993 I have lacked (and missed) the regular contact with trainees both pre- and post-Membership that was an important aspect of my clinical practice. Nevertheless I have long experience of the examination system as examinee, examiner and observer, and I do have opinions about it.

Should the long case be retained in the MRCPsych Part II examination? Is it fair? Certainly every long case is different and issues such as the venue affect the choice of patients, for example alcoholism in Scotland, or chronic psychosis where there are any long-stay beds remaining. Regional variations in accent and dialect can greatly add to problems of comprehension and how much more difficult that must be for the increasing number of young doctors for whom English is not their first language. The use of actors as simulated patients alleviates that problem. Their diction is clear, they know the storyline and they are well-schooled in the psychopathology which they need to convey. And objective structured clinical examinations (OSCEs) are now established as the clinical arm of the MRCPsych Part I.

In many ways, then, OSCEs can provide an answer to the perennial problems that beset the organisers and the examination system. Actors don’t default or they won’t be paid. They don’t need to occupy hospital facilities or hospital staff time. No need for up-to-date case histories in all their (often contradictory) complexity, with ICD–10 and DSM–IV underpinning the diagnoses. How much easier to invent a narrative for the actor, then leave him (or her) to develop the scenario in the best tradition of modern theatre, interacting with the co-lead (or examinee) with a captive audience (the examiner/critic) who will mark the performance according to an agreed format. However, the OSCEs have been considered unsuitable for the assessment of more advanced psychiatric clinical skills, and this conclusion ( Hodges et al, 1999) was justification for retaining the use of the long case in the Part II examination (Tyrer & Oyebode, 2004).

It must be tempting to use actors to simulate the long clinical case. But real clinical practice is not easy, nor is it fair. Patients in all their infinite variety are unique and individual, challenging and difficult. They are what psychiatric practice is all about and this is precisely the problem if the long clinical case is lost.

The old Maudsley-style formulation, with its focus on the three ‘Ps’ (predisposing, precipitating and perpetuating) in the psychodynamic contribution to aetiology, was and remains an important aid in considering diagnosis and management in the long case, as in everyday clinical practice. The candidate is required to think analytically, to reflect and to draw conclusions. There is interaction between patient and candidate in the long case, requiring more than information-gathering or picking out

†See pp. 441–442, this issue.
The long case is dead†

The Editorial by Benning & Broadhurst (2007, this issue) is an impassioned *cri du coeur* bemoaning the abandonment of the long case examination in the MRCPsych examinations. In Spring 2008 the clinical examination will consist of an objective structured clinical examination (OSCE) in two parts and both the patient management problems and the individual patient assessment (the long case) will be discontinued; this is a substantial change in emphasis.

The authors correctly point out that the long case examination has been used for over 150 years in final medical examinations and believe that the cessation of this test will lead to a failure to test 'the ability to integrate and synthesise all of the information obtained from an interview [with a patient]'. This part of the MRCPsych examination was until a few years ago considered to be the most important component of both the MRCPsych Part I and Part II examinations, and failure in this section of the examination in either part meant an irretrievable fail whatever the results in the other components. Candidates who took the MRCPsych examinations in the late 1980s and 1990s will be aware of the importance of taking the long case. Loss of the MRCPsych long case. The long case is dead—long live the OSCE examination by removing the long clinical case or replacing it with simulated scenarios would give a very odd message about the importance of the patient’s experience, not only to trainees but also to our patients.
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