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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.

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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.

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rote-learned remedies for a range of diagnoses. The great Sir William Osler told his students, 'Only listen to the patient, and he will tell you the diagnosis', to emphasise the importance of careful and thorough history-taking (Osler, 1905). And the remarkable physician Francis Peabody wrote that 'One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient' (Peabody, 1927).

Increasingly technology encroaches on clinical practice in all branches of medicine. It is easier to look at the computer screen than to encounter the patients' fears, feelings and real-life experiences. The National Institute for Health and Clinical Excellence tells us what to do (cognitive–behavioural therapy for all; the latest 'wonderdrugs' promoted by the pharmaceutical industry; interrogation via computer programs to help with self-diagnosis) and we ignore the current trends at our peril. Or could it be that we go along with these changes and lose our professional identity, to the detriment of our patients and our discipline?

We live in changing and challenging times as far as our specialty is concerned. Scientific research and evaluation underpins our practice; advances in neurophysiology, neurochemistry, genetics and advanced imaging techniques have increased our knowledge and understanding of some of the mechanisms underlying mental illness. We now know that environmental factors influence the way in which genes are expressed (Suomi, 2006) and that early experience and serotonin transporter gene variation interact to influence primate central nervous system function. We know that early infant experience is crucial in right brain/left brain maturation, and that personality development depends on satisfactory early interpersonal communication and relationships (Schore, 1994, 2003*a*,*b*). We know that nutrition and environmental toxicity influence both the development and function of the nervous system. This is truly a holistic approach, and one that any competent candidate should be able to demonstrate in the long clinical case.

The biopychosocial orientation can now encompass neuroscientific models; it should not be seen as an either/or situation. A simplistic and reductionist approach does not do justice to the complexity of individual human suffering. Neuroethics will be an important aid to decision-making for clinicians, as Benning & Broadhurst point out, but accounts of subjective experience as case history should always be the most important way in which we gather personal information. To simplify the 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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STEPHEN TYRER

Non mors praematura: Commentary on . . . 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 future 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

†See pp. 441–442, this issue.