advertising these opportunities shortly, so look out for this if you are interested.

Psychiatry has the MRCPsych examination as the principal summative assessment of satisfactory completion of core specialist training. This, we believe, remains a reliable and essential test of the acquisition of the knowledge and competencies expected of a psychiatrist who is ready to progress to higher training. The current rating system for WPBAs in Assessments Online, however, does not sufficiently emphasise the essentially formative function of the process. As a consequence, many trainers have found it difficult to give robust and honest feedback and we have all become aware of the phenomenon of the trainee with a portfolio of perfect WPBA scores, baffled by their failure to pass the CASC exam. We are investigating ways of making the scoring system simpler and more aligned with judgements based on satisfactory development of competences in maintaining patient safety.

Workplace-based assessments, if used correctly, can be a powerful formative training tool. At the very least, they provide an opportunity for trainees to have their practice and competencies observed in a protected and structured manner. The challenge for trainers, the College and trainees themselves is to embrace the cultural training change that WPBAs represent so that they are used to support effective training. Workplace-based assessments are primarily a tool for helping an experienced clinician give robust and valid feedback to another clinician. To treat them as a tick-box exercise is to miss the point and lose their value. Those of us responsible for guiding members and trainees through the new training mechanisms have probably not been sufficiently clear or realistic about what is expected from trainers and trainees and there has certainly been a lack of clarity about the overwhelmingly formative function of WPBAs. For this we are sorry. We are learning too, and hope that the changes that we have outlined in this letter will move things forward. The College, too, must expect to receive robust and valid feedback about training initiatives, and we hope that colleagues will continue to survey trainer and trainee experiences and that we will be seen to act constructively and purposefully in response. We all want the highest possible quality training for psychiatrists and have to make the best use of the tools available.

1 Menon S, Winston M, Sullivan G. Workplace-based assessment: survey of psychiatric trainees in Wales. *Psychiatr Bull* 2009; **33**: 468–74.

2 Babu KS, Htike MM, Cleak VE. Workplace-based assessments in Wessex: the first 6 months. *Psychiatr Bull* 2009; **33**: 474–8.

3 Oyebode F. Competence or excellence? Invited commentary on... Workplace-based assessments in Wessex and Wales. *Psychiatr Bull* 2009; **33**: 478–9.

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doi: 10.1192/pb.34.3.114a

Medicalisation of stress belittles major mental illness

Few would argue with Professor Kingdon when he states that 'Everybody gets stressed . . . it's just the way we react that differs'.[1] Indeed, as Kingdon asserts, there can be no doubt that continua exist between normality and certain states currently classified as mental disorders. However, the artificial dividing lines towards the ends of each spectrum, set purely by societal expectations, surely call into question the validity of those very diagnoses that have perpetuated the myth of massive unmet need in psychiatric services.[2] Rather than adopting a stress model of diagnosis based on dimensions, perhaps diagnoses such as mild depression, social phobia and personality disorder should instead be dispensed with altogether.

On the other hand, major mental illness is not primarily stress-induced. Although environmental risk factors exist for schizophrenia, bipolar and unipolar (endogenous) mood disorders and dementia, there is no convincing evidence to suggest that these illnesses are any more likely than peptic ulcer, cancer or myocardial infarction to be triggered by psychosocial stress.

Furthermore, in psychiatric practice, a diagnosis is not a checklist of symptoms; it is a process we have each spent many years learning to craft. Symptoms and signs such as hallucinations and delusions undoubtedly sit on continua, but it does not follow that schizophrenia sits on a similar continuum. Using Kingdon's analogy, chest pain may vary in aetiology and sit on a continuum of frequency and severity, but myocardial infarction remains a categorical diagnosis.

Lastly, one should not reconceptualise and reclassify mental disorder as a response to the stigma attached to it. If cardiac illness were to suddenly become stigmatised, I doubt physicians would rewrite the diagnostic criteria for myocardial infarction. On the contrary, diagnosis would remain necessary for both immediate and long-term management, and it would still be vitally important to separate those with cardiopathy from those without.

1 Kingdon D. Everybody gets stressed . . . it's just the way we react that differs. *Psychiatr Bull* 2009; **33**: 441–2.

2 Richman A, Barry A. More and more is less and less: the myth of massive psychiatric need. *Br J Psychiatry* 1985; **146**: 164–8.

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doi: 10.1192/pb.34.3.115

Laughlin Prize winners: some further thoughts

It seems entirely reasonable to argue that the number of e-letters (letters submitted online to the journal in response to an article) and/or e-responses (email responses to the corresponding author) an article receives is a proxy measure of the interest generated by the article and also the wider interest in the journal. Albeit lacking the robustness of the 'impact factor', why not call this the journal 'interest factor'? Although letters to the editor are way down the 'importance' hierarchy of academic publications, my letter on the Laughlin Prize[1] still had six e-responses from trainees and four from the Laughlin Prize winners, hence my inference that *The Psychiatrist* probably has a high interest factor among its readers.

I give below an excerpt from an e-response I received from Professor McKeith, who won the Prize in 1981. I feel it is worth sharing because his eloquent, insightful and humble account answers three questions I set out to answer in my survey (to find out more about the winners, their preparation

for examination and whether winning the prize influenced their later career choice).

> Tidying my office for Christmas I came across your letter in November's *Psychiatric Bulletin*. As [the Laughlin Prize] winner in 1981 I fall outside of your survey dates but am intrigued by it. I agree that it is a rather uncelebrated achievement and the personal characteristics of . . . winners may account for some of that. It did have an influence on me I think, although one never knows what the alternative future would have looked like. I have met three other Laughlinites who have passed through my Department and I also went to visit Dr Henry P. Laughlin and his wife when I worked in the [USA] on an RCPsych travelling fellowship. They were a delightful couple. For what it is worth I agree with your extrapolation from a small sample size that enjoying the exam contributes to success although I also think that there is a huge amount of luck involved. My recollection of the Membership Exam (as it then was) was of a good day out and of not being at all intimidated by my two very distinguished London based psychotherapist examiners. I suspect that I could do this because I had been fortunate enough to have been trained in a first class centre where I was used to such grillings and it was relatively easy to take the exam in my stride as no different to my normal daily routine.

1 George S. The 'special' ones: survey of Laughlin Prize winners (letter). *Psychiatr Bull* 2009; **33**: 438–9.

Acknowledgement

I thank all e-respondents and in particular Professor Ian McKeith who allowed me to share his thoughts.

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doi: 10.1192/pb.34.3.115a

Empowerment and the recovery model

I would not argue against the underlying principles espoused by Sugarman *et al*[1] and Warner.[2] The principle of working with patients to help them to make informed decisions about options for their healthcare is embodied in the General Medical Council's (GMC) guidance,[3] which says that doctors must listen to and work in partnership with patients, and respond to their preferences.

Many psychiatric disorders are exacerbated or precipitated by stress. Autonomy of action is associated with enhanced self-esteem, reduced stress and improved health. Meaningful employment contributes in many ways, giving a sense of purpose and value, enhanced social status, structure and stability, opportunities for social interaction, and improved leisure and social opportunities as a result of greater disposable income.

Those working with individuals who have mental illness should be aware of these principles and seek to incorporate them in the care they offer. In practice, however, professionals nominally subscribing to a 'recovery model' may have a poor understanding of its complexity. An inappropriate application of the concept of empowering patients can lead to a laissez-faire approach of simply endorsing the patient's choice. This can result in justifying a patient's discontinuation of treatment and withdrawal from engagement with professionals. Such withdrawal can lead to relapse and a deteriorating prognosis, and may itself be indicative of incipient relapse.

Professionals do not enjoy a monopoly of wisdom. We cannot reliably predict the course of a patient's illness or how they might respond to treatment. Those with capacity have the right to decide not to accept treatment or to deal with their illness in ways which professionals may consider unwise. However, GMC guidelines also say that doctors must provide effective treatments based on the best available evidence. The doctor's duty to provide the best advice may include advising a patient that their intended course of action is likely to lead to an adverse outcome. It is incumbent upon us to inform patients of the probable consequences of their decisions and to continue efforts to engage them when we consider them to be at significant risk of deterioration or relapse.

Additionally, UK and European law takes a special view of mental disorder and allows for the patient's autonomy to be overridden. It is a matter of judgement, governed by legislative safeguards, as to when this should occur. Such powers are generally only exercised when the patient's ability to understand is so impaired as to render them incapacitated but a decision to override the decision of a capable patient may be made when the protection of others is in question.

It is right to adopt a positive approach, hopeful of recovery, after a first episode of psychosis. However, rather than adopt unqualified optimism, we should refine our approach using our knowledge of factors favouring a good prognosis. Such features include: acute as opposed to insidious onset; clear and proximate psychogenesis; and the presence of marked affective features in the symptomatology. Several interventions can improve the prognosis and reduce the risk of relapse. Warner[2] points out the more favourable prognosis in low- and middle-income countries. One explanatory hypothesis is that the recovering patient is more likely to have a valued occupational role. Continued antipsychotic medication reduces the risk of relapse. Psychosocial interventions to assist the patient in better understanding the illness and its behaviour, as well as working to modify family attitudes and environments appear to help. Complete resolution of symptoms encourages optimism about prognosis, but hopes for a meaningful and lasting recovery need to be underpinned by appropriate support and treatment to reduce the risk of relapse.

Despite the advances made in treating the acute symptoms of schizophrenia and preventing acute relapse, social recovery rates do not appear to have improved since Eugen Bleuler coined the term schizophrenia.[4] Warner quotes a 40% social recovery level but, at the start of the 20th century, Bleuler considered that 60% of his patients showed only 'mild deterioration', that is, had preserved the ability to pursue an occupation.

Whereas, therefore, I accept that significant numbers of patients with schizophrenia can remain symptom-free and that others lead reasonably productive lives, it is still the case that the majority will experience a degree of impairment of function