assessments (WBPA) or should the obvious conclusion be that there is no correlation between demonstrating competence in clinical practice and performing in an exam (something many may argue has been present all the time)? Should we then do away with the final exam altogether (as run-through training under Modernising Medical Careers may allow in some specialties) or return to the old-fashioned part II clinical exam which some (examiners and trainees alike) may argue was a better test of clinical competence and, more importantly, excellence? These are very important questions that the College and the Postgraduate Medical Education and Training Board need to consider, as one should not lose sight of the ultimate goal (becoming a specialist/consultant) of being in a postgraduate medical training programme in any specialty.

Following Lord Darzi's recent review of the National Health Service (NHS),[4] it has become ever so important for consultants to be at the forefront of driving quality in the modern-day NHS, something that will be difficult to achieve if we do not produce adequate numbers of quality-trained consultants. This may paradoxically suit many strategic health authorities, primary care trusts and NHS trusts! Many medical managers like me are constantly put under pressure to reduce medical costs (there is anecdotal evidence that consultant posts are not being advertised or retiring consultants are not being replaced throughout the country). As consultants remain relatively expensive units, it would suit the NHS ultimately to have fewer. New Ways of Working[5] is another tool of reducing consultant workload and perhaps ultimately numbers. Thus, if we continue with the current framework of training and assessment, we may inadvertently be facilitating that process.

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.

4 Lord Darzi. *High Quality Care for All: NHS Next Stage Review Final Report*. TSO (The Stationery Office), 2008.

5 Department of Health. *New Ways of Working for Psychiatrists: Enhancing Effective, Person-Centred Services through New Ways of Working in Multidisciplinary and Multiagency Contexts*. TSO (The Stationery Office), 2005.

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We all have thought processing difficulties from time to time . . . it's just the way we react that differs

The underlying issues raised by Kingdon[1] and King[2] are those in the foundations of the theory and practice of psychiatry. Interestingly, the views expressed echoed, at least in part, some of my own views expressed in another publication:

'Mental illness is never far away as it is simply one end of normality. In other words, we all have thought processing difficulties (TPD) from time to time. Depression is the best example of a thought processing difficulty. However, difficulty may become a disorder when the normal thought processing mechanisms and adaptations fail. A basic mental breakdown, without complicated diagnostic categories, takes place. The manner of the breakdown is unique to the individual sufferer whose internal life is surely more than the standardised criteria set in the scriptures (ICD–10 and DSM– IV)!'[3]

The definition of stress adopted by the UK Health and Safety Executive recognised it as relating to pressure and demands: 'the adverse reaction people have to excessive pressures or other types of demand placed on them at work.'[4] The intuitive thinker will immediately see the metaphorical relationship to a hydraulic or fluid-based system. If we accept that the mind is metaphorically fluid, then there will be no real boundaries and categories, making vague but universal concepts valid according to the demands of the specific situation. Thought processing difficulty/disorder is as defensible as 'stress' from a psychopathological perspective as well as in terms of social acceptability and (best of all) accuracy. I have creatively used the acronym TPD (with 'D' meaning either difficulty or disorder according to the patient's preference) to successfully resolve diagnostic disputes with virtually all my patients who felt stigmatised and erroneously labelled as schizophrenic or as having borderline personality disorder. Most chose 'D' as representing a difficulty for which they seek help in a collaborative fashion. It is of course less bruising to anyone's ego to accept having a difficulty (or stress) than to accept having a disorder (an implicit indication of socially undesirable or deviant behaviour). Thought processing difficulties/disorder has indeed been my Occam's razor for all psychiatric diagnoses and I recommend it to fellow colleagues. I understand that it will not be specific enough for the 'square thinker' – to use Robert Pirsig's reflection of the views of some African Americans who believed that too much intellectuality and too little soul made a person square. Such a person could not recognise quality, and nothing was real for them unless it was put into boring categories and defined.[5]

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

2 King M. Reducing the stigma of public health messages. Invited commentary on . . . Everybody gets stressed. *Psychiatr Bull* 2009; **33**: 443–4.

3 Metseagharun T. *ABC of the Mind: Very Simple Knowledge of the Mind That Promises You Happiness and Fulfilment*. AuthorHouse Publishing, 2008.

4 Health and Safety Executive. *What is Stress?* Health and Safety Executive (http://www.hse.gov.uk/stress/furtheradvice/whatisstress.htm).

5 Pirsig RM. *Zen and the Art of Motorcycle Maintenance: An Inquiry into Values*. Morrow, 1974.

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Screening tests for dementia

Only a tiny proportion of the laboratory and radiology tests identify potentially reversible causes of dementia.[1] However, I would like to sound a note of caution against reducing the use of blood investigations like vitamin B_{12}, folate and thyroid function tests in practice.