While we must continue to encourage people to join the most fascinating field of medicine, we also need to get our house in order.

1 Brown N, Vassilas CA, Oakley C. Recruiting psychiatrists – a Sisyphean task? *Psychiatr Bull* 2009; **33**: 390–2.

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

3 Craddock N, Antebi D, Attenburrow M-J, Bailey A, Carson A, Cowen P, et al. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.

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Are psychiatrists natural leaders?

Professor Buckley is arguing for training in leadership skills for psychiatrists.[1] He has not, however, made an obvious distinction between leadership and management, although they can be considered two separate attributes. Management is more of the here and now, the day-to-day stuff, the efforts to keep the wheels moving, as opposed to leadership which involves almost designing a new or better set of wheels. Leadership is about the future – the ability in some ways to be able to look into the crystal ball, get others to look too and somehow achieve that vision. Leadership is much more challenging, although day-to-day management looks as if there are no more challenges left. Leadership is, of course, much more satisfying.

There is also an argument whether leaders are born or can be made. Is the US president, Barack Obama, a born leader or is he a product of the PR gurus working overtime? Were Mandela or Gandhi born leaders or just born into a situation that made them leaders?

It is even more difficult to argue that psychiatrists are natural leaders. In our profession it is usually said that we need 'good communication skills' – every candidate for a post in psychiatry will put this down as one of their attributes. But what does this mean? What communication skills are we talking about? When we are training, the non-verbal communication is always pointed out as an important part of assessment. When we talk about communication, do we mean listening skills too? Are well-known world leaders good listeners as well? Or do we identify them more with their oratory skills?

It is a myth to think psychiatrists are natural leaders. We must not delude ourselves in thinking so. If anything, we just about match up to the rest of the medical profession. We have had good leaders in psychiatry, but we need better ones. It almost looks as if we need to make some, they are not born these days.

1 Buckley PF. Leadership development: more than on-the-job training. *Psychiatr Bull* 2009; **33**: 401–3.

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Doctor's ethnicity also matters

Nilforooshan *et al*[1] recently examined the rates and outcome of appeal against detention under the Mental Health Act 1983 for different ethnic groups. They found that Black Caribbean and White Irish groups, although lodging significantly more appeals compared with other ethnic groups (at 63% and 68% respectively compared with 39% White British), were under-represented in the group of patients who successfully had their detention discharged. These findings are revealing, but they would have been more useful if the ethnicity of the tribunal members overseeing the appeal had also been taken into account.

The 2005 Census by the Royal College of Psychiatrists[2] reveals the ethnic breakdown of British psychiatrists by grade and highlights the increasing ethnic diversity of psychiatrists in Britain today. Morgan & Beerstecher[3] recently studied general practitioners' practices and found that ethnic minority patients tend to be cared for by ethnic minority doctors. Hence any analysis of the impact of ethnicity on the individual treatment of a patient and of the system of care as a whole would be incomplete and potentially flawed without the inclusion of the ethnicity of the professionals involved. In the decades-old debate on the institutional racism of mental health services, the trend so far has been to assume by default that psychiatrists are ethnically or culturally White British. It is important that future studies take into consideration the evolution of the workforce in terms of ethnicity, but also gender and social class.

1 Nilforooshan R, Amin R, Warner J. Ethnicity and outcome of appeal after detention under the Mental Health Act 1983. *Psychiatr Bull* 2009; **33**: 288–90.

2 Royal College of Psychiatrists. *Annual Census of Psychiatric Staffing 2005*. Royal College of Psychiatrists, 2005 (http://www.rcpsych.ac.uk/pdf/Census%20results%20-%202005.pdf).

3 Morgan C, Beerstecher HJ. Ethnic group and medical care: what about doctor factors? [letter] *BMJ* 2009; **339**: b4060.

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WPBA or CASC/OSCE: where is it going wrong?

I have been involved in all aspects of training and workplace-based assessment (WPBA) as a consultant, chair of annual review of competence progression panels and a Royal College of Psychiatrists' examiner for the past 6 years, and experience the problems discussed by Menon *et al*[1] and commentators[2,3] regularly. The inherent weaknesses of WPBAs have been well documented in these studies, but one also needs to seriously consider why trainees who are proclaimed as competent in clinical skills (as evidenced by successful WBPAs) are performing so poorly at the College's Clinical Assessment of Skills and Competences (CASC) exam, where the success rate has dropped to less than a third?

As an examiner, I sometimes have been exasperated at the poor standards of performance in the recent CASCs where problems have been evident in all aspects of clinical and communication skills (knowing, knowing how, showing how and doing). Is that a reflection of failure of training systems and

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.