



editorial

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The long case is dead – long live the long case

Loss of the MRCPsych long case and holism in psychiatry[†]

As part of a radical overhaul of all aspects of psychiatrists' training in the UK, the Royal College of Psychiatrists recently published proposals to alter the format of its MRCPsych membership examinations (see <http://www.rcpsych.ac.uk/exams/newassessmentprogramme2008.aspx>). These proposals occur in the context of increasing public scrutiny of the medical profession and an attempt to tightly regulate medical education and continuing professional development in all of its branches. In recent years, this has led to objective improvements in undergraduate medical studies, particularly by placing emphasis on the importance of medical holism and ethics. These improvements in basic medical education should remain applicable to postgraduate specialist training, particularly in a specialty such as psychiatry, where these issues assume specific relevance. To an extent, the current curriculum for basic specialist training parallels these developments by encouraging awareness of ethical issues and promoting holistic (bio-psychosociocultural) thinking in psychiatry (Royal College of Psychiatrists, 2006).

The MRCPsych examinations have been in existence since shortly after the formation of the Royal College of Psychiatrists in 1971. Since that time, the examinations have been split into theoretical and clinical components, and the clinical component has included a long case or individual patient assessment. Despite the assumption that many of us may make that the long case is a recently devised examination technique which has passed the rigorous scrutiny of modern medical education, its origins are in fact somewhat more historic. The long case examination as a technique for assessing clinical skills originated in the mid-19th century in Cambridge. Until recently the long case was the cornerstone of the clinical component in both the MRCPsych Part I and Part II. However, the examinations have been subject to change over the years; one of the most significant in recent times has been the introduction of the observed structured clinical examination (OSCE), lauded as the solution to the problems inherent in long case examinations, particularly the difficulties of assessing a candidate on the basis of a single case which cannot be standardised for diagnostic complexity, cooperation of the patient, style of the examiner and so on. In 2003, the long case

examination in the MRCPsych Part I was replaced by an OSCE. However, despite evidence of the OSCE's validity in the assessment of undergraduate psychiatric training (Hodges *et al*, 1998), the same investigators later concluded that this type of examination when marked with a checklist would be unsuitable for the assessment of more advanced psychiatric clinical skills (Hodges *et al*, 1999). In 2004 past chief examiners of the Royal College of Psychiatrists, Professors Tyrer and Oyeboode, considered this their justification in proposing the continued use of the long case in the Part II examination (Tyrer & Oyeboode, 2004).

Although the new format of the MRCPsych examination has now been published (see <http://www.rcpsych.ac.uk/exams/newassessmentprogramme2008.aspx>), changes are subject to approval by external bodies and the proposed implementation date is Spring 2008. We feel that it is vital for this important issue to be considered widely.

If there is concern over unacceptable levels of bias in the existing examination system, then a serious attempt to introduce an equitable and fair alternative is welcome. A more standardised format may serve these interests but further thought needs to be given, we believe, to the implications of proposals to abandon the long case in favour of an OSCE-based system. For all that stands to be gained, there are likely to be negative implications not only in terms of education and training but also to the culture of psychiatry and such issues require further considered reflection and debate. More than simply serving a symbolic function, the long case represents a commitment to a holistic approach, which psychiatry has historically had to fight to preserve in the face of various reductionist influences. The long case is integral to the bio-psychosocial approach, which has had a significant influence on British psychiatry since the 1970s when it became, in the words of Pilgrim (2002), 'established as psychiatric orthodoxy'. The bio-psychosocial model's commitment to situating clinical signs and symptoms in the context of the unique and individual aspects of patients' histories or biographies accords central importance to an individual's personhood. The bio-psychosocial model then privileges the patient and the longitudinal

[†]See pp. 446–447 and 447–449, this issue.



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context of illness, and is therefore humanistic as well as scientific (Pilgrim, 2002).

However, commentators in recent years have noted the decline of the ideals embraced in the bio-psychosocial approach. This is reflected, for example, in the diminishing importance placed on bio-psychosocial formulation in current training and practice. Such concerns inevitably go hand in hand with a critical stance towards the currently prevailing biomedical or neuroscientific paradigm, which is perceived as having an undermining influence on the bio-psychosocial model.

In a climate where a strong ethic of standardisation permeates all aspects of practice (audit, National Institute for Health and Clinical Excellence guidelines, etc.) there is a danger that the new proposals for examination reform, for all their purported benefits, as an expression of this ethic will actually lead psychiatry a few more steps away from the ideals of the bio-psychosocial approach and from the holistic ethos underpinning it.

Standardised approaches, by definition, encourage uniformity and facilitate administration on a large scale with relative efficiency but ultimately tend to overlook individual differences in favour of collectivising designations.

Standardisation only works by simplifying what is complex. It privileges the acquisition of (objective) data which is 'easy to acquire and to measure' and it de-emphasises the acquisition of (subjective) information which is more difficult to obtain. As it so happens, the subjective elements of experience are those upon which difference is stressed. Inevitably then, a view of mental illness is reinforced which leans towards precisely that position against which the bio-psychosocial model and its theoretical precursor, Meyerian psychobiology, was intended to safeguard. A neglect of the subjective elements of experience risks negating those unique aspects of psychiatry that define it as a specialty and which set it apart from, for example, neurology (Pies, 2005).

A key skill for psychiatrists to cultivate throughout their careers is the ability to integrate and synthesise *all* of the information obtained from an interview, and this process can never lend itself to examination in an OSCE format or in a 'station'. Concern has also been expressed that the move towards neuroscientific explanations of normal and pathological behaviour relegates the importance of individual biographies (Martin & Ashcroft, 2005). We therefore pose the question, 'Is the proposed abandonment of the long case symptomatic of this

reduced emphasis on biographical accounts of behaviour at a time when there is a bias towards explanations based on neuroscientific models?'

Such questions are being asked within the emerging specialty of neuro-ethics, in which ethico-legal, philosophical and social implications of neuroscience and related technologies are under consideration. The possibility that such factors might be covertly influencing psychiatric education needs to be acknowledged and debated within our profession too. The retention of the long case needs to be understood by the College as an indication of its commitment to a bio-psychosocial orientation.

Psychiatry, obviously does not lend itself to 'snapshot' or 'foot of the bed' diagnoses and its relationship to signs and symptoms is not analogous to medicine's relationship to, for example, a raised jugular venous pressure or an enlarged spleen. Most psychiatrists would not currently dispute this. However, we are concerned that the loss of the long case may subtly shift the culture of psychiatry in a direction in which the failings of this analogy may no longer be so apparent.

Declaration of interest

None.

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