columns

Eagles continues, stating that conclusions and recommendations do not stand up in the absence of these data, since any consultant not in a sufficiently populated, effective team would not survive in a progressive role.

My initial response is to state that we indeed did collect data about the size of the respondent's team. These data weren't included in this paper as submitted to keep the length down to publishable level. In common with many national studies, the original dataset for this project is vast and contains several hundred variables. We are forced to choose not only which to analyse in depth, but must create a subset of those to submit for publication in peer-reviewed journals. I can report, however, that team size was included as a predictor in some of our univariate (the larger the respondent's team, the higher their reported satisfaction level [$P<0.05$]) and multivariate (the larger the team, the lower the respondent's General Health Questionnaire – version 12 score ([$P<0.05$], and the less they suffer from depersonalisation [$P<0.01$]) analyses. My second point concerns Dr Eagles' interpretation of the findings more generally. I feel that Dr Eagles has rather missed the point of this paper: the progressive model can only ever work where the consultant has a motivated, effective multidisciplinary team. A progressive role, by reference to its defining characteristics, cannot be achieved without it. Further, the more important point here is that a consultant cannot change in isolation: as we point out in the paper, any change of role is potentially dangerous unless carried out as part of a whole-systems approach to change, a restructure, where due consideration is given to ensure that any reduction in workload is not merely passed onto other team members, rendering them liable to stress and burnout.

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Partners in care. Who cares for the carers?

Mike Shooter, President of the Royal College of Psychiatrists has highlighted an important aspect of psychiatric care in his recent editorial 'Partners in care. Who cares for the carers?' (*Psychiatric Bulletin*, September 2004, **28**, 313–314).

This is very relevant to the developing countries as many clinicians depend heavily on relatives or carers with regard to various aspects of a patient's management, as social services and other supportive systems are poorly developed. For instance in many in-patient units in Sri Lanka, relatives or carers are encouraged to stay with the patients. Sometimes relatives take turns to stay with the patients to minimise the burden and disturbance. This helps 'overworked staff members' to alleviate the burden at least to some extent. When the patient is discharged from the in-patient unit, administration of medication and rehabilitation programmes are done with the help of the carers. Carers are further distressed prior to the admission of a patient for assessment or treatment. For instance as the existing mental health act does not address the admission policy comprehensively in Sri Lanka, relatives or carers have to play a major role in accommodating the disturbed patient until taken to a hospital for assessment/treatment/admission.

The other important area is the rapidly increasing elderly population in developing countries. At the moment many elderly people are looked after by their family members. For example, in Sri Lanka about 80% of the elderly population are living with their children and the main caregivers are female (National Council for Mental Health, Sahanaya, 2002). We are bound to see more and more people with dementia and other disorders encountered in old age. Services for the elderly are not well developed compared with the West and the families, particularly females, are expected to look after their elderly relatives.

The other important area that needs to be highlighted is the introduction of community care without many resources. Management of mentally ill people in the community without resources will add to the burden on the carers. It is noteworthy that the crisis assessment teams are either poorly developed or non-existent in many developing countries.

We totally agree that the concept of 'caring for the carers' should be further emphasised and the undergraduate and postgraduate medical and nursing curricula must be strengthened with regard to this aspect of care.

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Irish Psychiatric Association survey of psychiatric services in Ireland

The article by O'Keane *et al* (*Psychiatric Bulletin*, October 2004, **28**, 364–367) provides a valuable insight into the deficiencies present in mental health in the Eastern Regional Health Authority (EHRA) in Ireland. Unfortunately the data presented do not represent 'a national survey'. The consultant sample is only 8.2% of the 281 consultant psychiatrists employed in Ireland (Walsh, 2004) and hence the results of this survey are limited to only the EHRA respondees. The wide variation in the socio-economic and demographic profiles in different regions in Ireland noted by the authors and elsewhere (Central Statistics Office, 2003) alongside the variation in the management style, and political function of the various health boards, and differences in regional infrastructure also make the EHRA results non-generalisable to Ireland as a whole without further data.

The paper is a good start at examining the inequities of Irish mental healthcare but data including regions very different from Dublin and the East coast are essential in such a survey.

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The objective structured clinical examination

The letter by Haeney (*Psychiatric Bulletin*, October 2004, **28**, 383) raises an interesting conundrum.

I have recently been advising a number of my colleagues, who will be undertaking the clinical examination for Part II MRCPsych. A significant number undertook the Part I MRCPsych OSCE exam, so have not had experience of the unobserved long case.

With the introduction last year of the OSCE exam and its widespread use in undergraduate teaching, a large proportion of trainees have no experience of long case examination. As was mentioned in the letter by Haeney, candidates struggle with the uncontrollable variables of patient and examiners. My own feeling about this is that, with experience, candidates can often handle these situations better. During my undergraduate training, I was examined using the traditional long case format, and I believe this exposure to the format gave me greater confidence when dealing with long cases in both Part I, and more recently, in Part II examination.

It would be of interest to get an idea of how candidates who are now undertaking Part II are dealing with the lack of exposure to the long case. This would particularly apply to any proposed change in the Part II examination. Having reviewed previous articles it would appear that

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