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