
columns

In a self-funded health economy, patients and their families paid for lodging in the village. The period of stay was longer, at times it ran into years, and some patients relocated to live permanently in the village.

Finally, the benefits were not couched in terms of econometrics, but in the confidence of the rural community to embrace the, then, alien Western psychiatry.

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Military psychiatry

Sir: Military psychiatry is, as Greenberg *et al* (*Psychiatric Bulletin*, June 2002, **26**, 227–229) suggest, a unique national resource. I agree (*Psychiatric Bulletin*, July 1997, **21**, 418–421) that it should focus on those areas in which it can justly claim expertise.

Greenberg *et al* state that military psychiatry is essentially occupational and they mention its 'ethical and moral' challenges. As a serving Officer, I was certainly aware of ethical tensions. On the whole, service personnel came to see me as a psychiatrist, not as an occupational physician. The occupational role, however, meant that under certain circumstances I had to act, not primarily in the best interests of the patient, but to safeguard the military. This possibility was not made explicit. Yet, military patients had few options but to be seen by military psychiatrists.

In civilian life, we can make more autonomous decisions concerning whom we see. The role of the occupational physician is explicit. Doctors only normally act against the wishes of their patients when there are substantial risks associated with not doing so. This is not always the case in the military, because the rules relating to mental illness are attuned to the needs of the organisation, not to personal needs. For understandable (but none the less stigmatising) reasons, the military environment is intolerant of what it perceives as mental illness. So, there can be an ethical tension between the occupational role and the therapeutic inclination. This ethical dilemma is another unique feature of military psychiatry and one that it would be interesting to see addressed.

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Overseas candidates for the MRCPsych examination

Sir: I read with great interest the article by Tyrer *et al* (*Psychiatric Bulletin*, July 2002, **26**, 257–263) on the MRCPsych examination.

The major findings of their study were: (1) doctors from the UK/Ireland fare much better than their counterparts from the rest of the world; and (2) the older the candidate, the lower the likelihood of success.

I would like to focus on the first point. In addition to the putative explanatory factors put forward by the authors to account for this finding, I would like to consider a few more. Compared to UK/Ireland graduates, overseas doctors are more likely to work in non-teaching hospitals for the whole of their basic specialist training. This will obviously impact on the quality of training they receive and, therefore, their level of preparedness to face the MRCPsych examination. Also, a not insignificant number of overseas trainees are forced by circumstances to take up non-career grade posts for visa purposes: permit-free training (PFT) visas for senior house officers (SHOs) are usually given by the Home Office for a total of 4 years. Understandably, for some, this period is insufficient to pass the examination. The overseas doctor, who sits his subsequent attempts at the MRCPsych examination as a staff grade, will obviously not have the same access to exam-related training as an SHO.

A study that controls for these potential confounding factors (Hospital of training: teaching *v* non-teaching, and post of the candidate: training *v* non-career grade) may be able to provide a more accurate picture.

From Table 1, in the Part I examination, 74% (305/410) of UK/Ireland graduates passed the multiple choice question (MCQ) examination compared with 57% (408/718) of overseas graduates, an absolute difference between the two groups of 17%. Among those successful in the MCQ component, 85% (206/305) in the UK/Ireland group and 54% (219/408) in the overseas group were also successful in the clinical component, an absolute difference of 31%. Why does the gulf between the two groups widen from 17–31% in just a few weeks between the written and clinical examinations? Is the clinical examination unintentionally biased against the overseas trainee?

Another striking statistic in the study is the relative percentage of overseas candidates appearing in the Part I and Part II examinations. Although in Part I, 64% (718/1128) are foreign graduates, in Part II this drops sharply to just 47% (357/763) with a corresponding increase in the UK/Ireland group from 36–53%. There may be several reasons for this, for example inability to pass Part I, dropping out of psychiatry or moving to non-training posts. Perhaps this is an area for further investigation?

It should not be forgotten that the Professional and Linguistics Assessment Board (PLAB) test, which most overseas doctors have to pass to work in the UK, is comprehensive and recognised to be of a high standard.

Finally, the College needs to be appreciated for its transparency in publishing the details relating to the MRCPsych examination. Also, it is encouraging to learn that there is going to be greater standardisation of the examination with the introduction of more reliable sections.

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Examination performance feedback

Sir: At present, only candidates who fail the College Membership examination are provided with performance feedback. The feedback is most useful, detailed and helpful in illustrating not only areas of weakness but also positive aspects in the failed performance. The information provided is invaluable to one's success in future attempts.

We believe that it is equally important that successful candidates are given the same opportunity to scrutinise their performance through similarly constructive feedback from the College.

The margin between success and failure may be only slight in a sizeable minority of cases and it is clear that, even after a success, room for improvement remains. With a detailed breakdown of one's performance, there could be at least some pointers for future learning.

We should stress that this suggestion is made with the intention of enhancing one's knowledge of one's abilities, certainly not to provide grounds for appeal nor to provide information for the construction of specialist registrar league tables! There is, naturally, a possibility that such a move may result in the deflation of one's moment of triumph. However, this can be avoided by allowing sufficient time between the euphoria of success and arrival of the detailed feedback for the successful candidates.

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