The College

1987 Trainees' Forum

The 1987 Trainees' Forum took place at the College's Winter Quarterly Meeting on 27 January 1987. The Meeting was attended by 43 psychiatrists, of whom 18 were consultants and seven of those were tutors. The Panel members at the Forum were: Dr J. L. T. Birley, Dean of the Royal College of Psychiatrists; Professor Robert Cawley, the current Chief Examiner, who both gave short introductory talks; Professor H. G. Morgan, Deputy Chairman of the Examiners' Board of the College; Dr Sally Pidd, Chairman of the Psychiatric Tutors Sub-Committee; Dr Jan Falkowski, Senior House Officer at St George's Hospital London and Dr Peter Rice, Vice-Chairman of the Collegiate Trainees' Committee. The contributors were chosen to represent the range of interested parties; the examiners, the tutors, the College Approval teams and, of course, the candidates.

The original intention of the Forum was to look at the changes in training resulting from the new examination. However, as the meeting progressed it became clear that trainees would also have to adapt to the new exam, and the opportunity to hear from examiners of the attributes they are going to be looking for was a valuable one for prospective candidates.

Implications for training

For those involved in College politics, the MRCPsych Review[1] seemed to have been widely discussed in the four years of its preparation and the 15 months since its publication and it was therefore surprising to find that many of those attending the Forum (presumably a self-selected interested group) were not familiar with the final Report. From my own perspective as a recent candidate, anyone sitting the new exam who has not read the Report (which is still available from the College on request) is putting him/herself at a considerable disadvantage.

In post-graduate psychiatric training there is traditionally a joint responsibility between the clinical tutor at the base hospital and the local day-release course and with the new exam it would seem that the balance of responsibility is shifting to the former. All consultants with trainees, particularly at an early stage of their training, will be expected to provide training in interviewing techniques (this can be done in various ways through observation by the trainee, direct supervision by the trainer or by the use of video), and to keep a close eye on the trainee's day to day work. It will be the responsibility of the clinical tutor to ensure that this is taking place. With proposed changes in the pattern of medical staffing in the future, fewer consultants will have trainees and perhaps those only willing and able to provide training as outlined above will have them. Furthermore, the change in College policy away from approving schemes towards approving individual training posts would fit in with this arrangement.

The emphasis on interview skills training raised the issue, both in the Forum and in discussions elsewhere, of whether such skills can be taught or whether they are innate. Professor Cawley felt that there had been sufficient reseach on interview training to suggest this could be taught and it is clear that Approval Panels will expect to see evidence of such teaching when they visit schemes on the approval exercise. A one-day pilot course for consultant trainers focusing on this issue has taken place in the South East Thames Region, and this may be a forerunner for future courses.

There was evidence that the changes in the examination are having variable effects on the traditional day-release course. Some are having difficulty adjusting to the new requirements and it is reported that in London and Birmingham trainees are voting with their feet and had stopped attending day-release, with considerable financial implications for the organisers. On the other hand, in Galway, the new proposals have provided the stimulus for a course being set up where there had not been one before.

There seemed to be two main difficulties for course organisers; firstly, the problem of trying to run simultaneous courses for the Membership examination in the old format and the new Part II exam. It was suggested perhaps the best solution to this was to aim the course at the new exam which would cover the syllabus for the old exam, the only difference being an increased emphasis on the basic sciences. Secondly, courses for the Part I required a completely new structure and there was a feeling that the learning of the basic clinical skill required for Part I could be done at the base hospital and that there may be no need for a formal lecture-type course in preparation for Part I. The consensus though was that this would be a regrettable development as some areas were already running apparently popular clinically-based Part I courses.

Implications for candidates

A frequent criticism of the MRCPsych (and of most other post-graduate medical examinations) is that it is an exam without a syllabus, the main requirement being to show that you are a competent psychiatrist. The Examination Board and Deans have traditionally, and perhaps wisely, resisted the temptation to issue a College definition of what a competent psychiatrist should know and the nearest thing

https://doi.org/10.1192/S0140078900018617 Published online by Cambridge University Press

to a syllabus for the old exam was *Guidelines on Sciences Basic to Psychiatry*, published by the Association of University Teachers of Psychiatry.[2] Perhaps in response to such criticism the Report for the new exam does contain some indication of the required knowledge for Part I (pages 7 and 8 of the Report) and Part II (pages 12 to 15).

(a) Part I

MCQ paper

As mentioned in the Working Party Report, this will examine basic psychopathology in two areas: descriptive psychopathology (otherwise known as phenomenology), and explanatory psychopathology (otherwise known as psychodynamic psychopathology), methods of clinical assessment, psychopharmacology, neuro-sciences and neurology. Psychopharmacology should be known to a level permitting safe prescribing (as might be expected from someone who has been working in psychiatry for at least a year) and the neuro-sciences and neurology to the level necessary for safe clinical practice, which is taken to be that required for the undergraduate finals.

Clinical examination

This is of course new to the Part I examination and it will only be once the exam is in use that the true level of performance expected can be established. There will be an induction course for all clinical examiners for the Part I in an attempt to standardise ratings and there will be two separate groups of examiners for Part I and Part II. It may be of interest to candidates that it is not anticipated that patients who require informants to give a history on their behalf will be used in the Part I.

The attributes looked for in the clinical examination will be the ability to interview the patient, to synthesise the information gathered and to present a coherent mental state examination. Interviewing skills will be assessed both from the history given by the candidate and from his/her performance during the ten-minute interview with the patient in front of the examiners. The examiners will be looking for the ability to relate well to the patient, to be sensitive to his/her feelings and to the control of the interview (the use of open and closed questions, when to allow the patient to digress, when to interrupt and so on). A detailed plan of management will not be required.

There was concern on the publication of the Report that it may benefit candidates to delay taking the Part I into the second and third year of their training in which case the exam would no longer be a test of basic clinical skills; however, it is hoped that the regulation precluding those who have been in training for more than three years from taking the exam will discourage postponement. It may be that success in the Part I examination will be used as a measure for promotion into the registrar grade and so this will also encourage early attempts. (It should be noted though that there are some pessimists who believe that the "Achieving a Balance" Manpower Proposals will leave trainees requiring full membership before promotion into the registrar grade).

(b) Part II

Changes in the Part II are less major than those in Part I. In the old exam it was anticipated (in my experience correctly) that candidates would have forgotten their basic sciences by the time they reached the membership examination. The thinking behind the new exam is that learning should be more integrated and that relevant knowledge of basic sciences should be part of everyday practice and the appropriate place for this knowledge to be examined is with the assessment of more advanced clinical skills in the Part II examination.

The traditional essay paper

In some ways the retention of the traditional essay is the most controversial part of the new exam, although the structure has been changed from the old format of four short essays to one essay written over one and a half hours from a choice of six. The Working Party are disarmingly frank about the deficiencies of the traditional essay paper in terms of its reliability and quoted that in 40% of papers the discrepancy between the two examiners' marks was greater than 20%. Despite this the essay has been retained, as it was seen as an important method of assessing the candidate's ability to integrate knowledge and to communicate this in a clear and concise way. All questions will have a basic science and a clinical component and the style of essay being looked for is perhaps best described by Dr Birley at the Forum. "A straightforward list of facts is not what is required but there must be some facts. We are not looking for interesting pieces of fiction on the structure and function of the hippocampus".

The MCQ papers

The Second Part will now have two MCQs, one on basic sciences and one on clinical topics. There has always been some criticism of the MCQs in the MRCPsych because some feel that MCQs cannot accurately test clinical judgement, sensitivity and the ability to apply reasoning, which is so important in clinical practice. The MCQ has been retained, however, because it was felt that while not perfect, multiple choice is the best way of testing certain kinds of factual knowledge. There is no evidence to support the assertion that some people "just can't do MCQs" as results tend to show that people's performance in the multiple choice is consistent with that in the rest of the exam.

There have been more specific criticisms of the standard of the MCQs in the MRCPsych over ambiguous questions and the use of ill-defined terms and the CTC has been in correspondence over this issue with the Examinations Board.

Short-answer questions

These are new to the exam and have been introduced in an attempt to provide MCQ type reliability yet to allow a broader range of subjects to be tested and to give candidates more opportunity for expressing their knowledge (or lack of it). The SAQ paper is deliberately designed so that the candidate has limited time to answer and I found the specimen

https://doi.org/10.1192/S0140078900018617 Published online by Cambridge University Press

paper issued by the College to be considerably more difficult than the other parts of the exam. As with the other major innovation, the clinical examination in Part I, it may take some trial and error before an appropriate level of knowledge for the short-answer questions can be established. This, of course, may be scant consolation to those who will have to act as trial subjects for this first two or three sittings.

The oral examination

Up until the last couple of years this was an unstructured 15 minute interview with a pair of examiners on any topic in psychiatry and it had been suggested that the Oral was really a test of the candidate's ability to read the examiner's mind (perhaps this is a skill which all psychiatrists should possess). In an attempt to standardise the Oral examiners were asked to prepare 'patient management problems' where the candidate is presented with a brief description of a clinical situation and assessment and management issues are discussed. This seems to have been successful in introducing rather more structure into the Orals and the use of patient management problems will be continued in the new exam, in which the Oral will last for 30 minutes as opposed to 15 minutes.

The clinical examination

This is essentially unchanged from Part II in the old exam. The term 'formulation' was dropped a few years back and the candidate is now asked to give an assessment which consists of the relevant factors in history, mental state examination and physical examination if indicated. The candidate is expected to make appropriate deductions from the information given, present differential diagnosis management plan and prognosis. As with the Part I clinical examination, the interview of the patient in front of the examiners is not just a test of your ability to demonstrate the niceties of phenomenology but also to establish a working relationship and rapport with your patient allowing for the mental state of both patient and candidate on the day.

Comments

In the preparation of this paper I discovered by chance a document produced by the Association of Psychiatrists in Training[3] on examination and training of psychiatrists following a symposium in Cardiff in July 1973. At that time I was more concerned with my O levels but those of greater seniority may recall their dissatisfaction which APIT reflected with the then recently introduced MRCPsych Examination.

The objections at the time were that the requirements of the exam were not the same as those of good clinical practice and that the exam would encourage a reductionist approach to psychiatric training and knowledge. The exam was described as "A passage rite for which presently the preparation is to stuff oneself with facts before being roasted." Candidates felt that the main function of the clinical examination was to apply the appropriate diagnostic label to the patient to the exclusion of all other factors and it was feared that the examination would lead to a concentration of more able trainees and trainers in a few already privileged centres to the detriment of the peripheral hospitals. These fears led to APIT suggesting a boycott of the examination, although I think that one can take it from the subsequent careers of prominent APIT members that they did at some point pass the exam.

Professor Rawnsley (at that time the Dean of the College) made the point that the approval exercise was likely to be of more importance in raising the standards of psychiatric training and practice in the Membership examination but I would suggest that the two in fact go hand in hand. Without the Membership examination and its importance to trainees as a necessity for promotion, the approval exercise would have considerably less bite and as the competition for higher training posts increases, the importance of having trained in a scheme with a good accreditation record becomes as essential as the possession of the MRCPsych.

The response of APIT to the introduction of the MRCPsych in the early seventies is in contrast to the response of the CTC (who are almost, but not quite their successors) to the first major revision of the examination 14 years later. Although there were a few dissenting voices, the CTC who were represented on the Working Party in general welcomed the new proposals. There are two possible reasons for this. The first is that the present generation of psychiatric trainees may be less radical, less imaginative and more passive than their predecessors and that the young Turks may be neutralised by assimilation into the College or that the College Working Party reviewing the exam in fact did a good job and that the new exam is an improvement on the old one. I favour the latter explanation.

PETER RICE
Vice Chairman of the Collegiate Trainees' Committee and Lecturer, University Department of Psychiatry, Ninewells Hospital, Dundee

REFERENCES

[1] WORKING PARTY FOR REVIEW OF THE MRCPSYCH (1985) *A Report to the Court of Electors*. Royal College of Psychiatrists.

[2] ASSOCIATION OF UNIVERSITY TEACHERS OF PSYCHIATRY (1982) Guidelines on sciences basic to psychiatry. *Bulletin of the Royal College of Psychiatrists*, **6**, 54–56.

[3] THE ASSOCIATION OF PSYCHIATRISTS IN TRAINING (1973) *Examinations and the Training of Psychiatrists*. APIT.

Christmas Cards

A pictorial reproduction of No. 17 Belgrave Square, from an original watercolour by Dr J. Horder, is available from the College at 20p each (plus postage of 53p per dozen). A second design is also available – the College Coat of Arms die stamped in colour, priced 35p each (plus postage of 31p per dozen).

https://doi.org/10.1192/S0140078900018617 Published online by Cambridge University Press