The College

The MRCPsych Examination

Professor Cawley meets the Education Committee

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The Working Party appointed to review the form, content and value of the MRCPsych examination is about to discharge its awesome brief. Professor Cawley, the Chairman, presented a preliminary report to the Education Committee on 14 September 1982. It is expected that the final Report will be submitted to the Court of Electors sometime in 1983. The recommendations will be implemented only after the current cohort of candidates has been allowed to complete their examination under the old regulations.

The primary function of any collegial examination is to assess professional competence. Secondarily it also fulfils a social role. Completion of the rite of passage puts the new member under the unspoken obligation of furthering the fraternity. In this way, patients, members and the College, all stand to win. The 'filter' function is the harder to achieve; the ceremonial one is satisfied as long as the examination is not seen as too easy, unfair or lacking in gravity.

General issues

Professor Cawley reported that the Working Party is of the opinion that the College should continue celebrating the examinations. The many modifications entertained have all stemmed from the same guiding principles, to wit, that examinations must be fair, and constitute an educational experience. They ought to help the trainee to identify gaps in knowledge and skills, and to become aware of the clinical relevance of the basic sciences.

The Preliminary Test

The Working Party suggests that the Preliminary Test becomes a test of basic clinical competence. To adjudicate, the examiners must be given the opportunity of actually seeing the candidate 'communicating' with the patient. It has not yet been decided whether this would be done by direct observation of by analysis of videotaped interviews. There should also be a written part to test factual clinical knowledge. Knowledge of the basic sciences would be tested only in the Final examination.

The Preliminary Test would still be taken after the candidate has worked for a year in a recognized post. Failure in the written examination would preclude the candidate from taking the practical section. After three failures, however, he would be allowed to take it anyway; the reason for this being that one of the crucial functions of the Preliminary exam is the identification of those who are unable to 'communicate'. As Professor Cawley delicately put it, they would then be persuaded to seek further career advice.

Members of the Education Committee queried a number of points. Given its filtering role, was not the Preliminary Test premature? After all, skills to communicate are not inborn and might take time to be learned. The techniques utilized in the written section were also called into question. Multiple choice questions were described by some as obsolete; others felt that the essay questions had not been successful for candidates often ignored the instructions (e.g. 'discussing critically') and wrote down lists of unconnected facts. A third format, consisting of 'expanded' answers, was suggested. Some felt that this technique fell between two stools. It was concluded that examination methods *per se* are neither good nor bad and that each taps a certain type of knowledge.

The need for a Preliminary Test at all was also questioned. Instead a single 'exit' examination was proposed. This could be complemented by continuous assessment and the keeping of a case book.

Continuous assessment

Examinations could be replaced, in the ideal world, by continuous assessment. A psychiatrist, when properly trained, should be able to show his clinical skills under diverse working conditions. It is this consistency that continuous assessment tends to measure well. In order to carry it out, however, better monitoring techniques than those currently used by national training programmes would have to be developed. Likewise, new functions would accrue upon the teaching role of the psychiatric tutor and the sponsoring consultants.

Psychiatric tutors would have to be given special training. Sponsors underwriting the application form would have to satisfy themselves that the candidate was ready for the exam. Sponsors might need to take up a role akin to 'personal tutors'.

The case book

A case book consisting of detailed case histories could be kept by the candidate. Writing up clinical cases in detail would encourage the trainees to think through their own clinical work. Some members of the Committee argued,

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however, that candidates with a natural flair for writing and those in centres of excellence might be given an unfair advantage. Likewise, the question of the authenticity of the cases could be on occasions difficult to settle.

The Membership Examination

The format of the Final Examination should also, in the Working Party's view, be changed and special emphasis put on assessment of clinical skills and case formulation. Simple and reliable techniques for interview, observation and evaluation were also needed in this case. Likewise a satisfactory definition of 'formulation' would have to be reached.

Potential candidates may be glad to know that the Working Party has suggested that the General Viva should be dropped and replaced by a 'second clinical' examination, the possible format of which might include simulated out-patient, community psychiatry or domiciliary visit situations. Examiners would be instructed to focus their attention on the following skills: interviewing, eliciting accurate information, examining the mental state, formulating and making a differential diagnosis, organizing a management programme and communicating with patient, relatives, other members of the team and GPs. Attention would also be given to the extent to which the candidate's clinical assessment is seen to draw upon existing knowledge.

The examination would still be taken after three years except in the case of 'high flyers' who might be allowed to take it earlier. Even in these cases, however, it is suggested that the diploma should be withheld until evidence is presented that a third clinical year had been completed. Members of the Education Committee were unhappy about this dispensation and wondered about criteria to define who an 'early taker' was.

Psychiatric specialisms

The question of proportional representation in the examination for child psychiatry, psychogeriatrics, psychotherapy, alcoholism and forensic psychiatry was also touched upon. The possibility was contemplated of allowing candidates to select certain topics and areas in which they had special expertise. This could be considered as an alternative to the common syllabus or as its complement. The final pattern must be determined by both educational principles and, more to the point, by consumer needs.

On the issue of how seriously the educational role of the examination should be taken, members of the Committee were also in disagreement. For some this function was paramount; for others the main business of examinations was to serve as a valid filter—as a good measuring instrument. It is obviously tempting to seek a reconciliation of these two views in practice.

Research options

The current research option in the Membership Examination has been poorly subscribed. Hence the Working Party suggests that it should be abandoned. Some suggest that the timing and content of the current examination may in fact distract trainees from their research interests or, worse, kill their creativity. It was retorted that there is no reason to believe that three years of intellectual and clinical work should be detrimental in this respect. It was, moreover, claimed that without this basic knowledge it would be difficult for the trainee to formulate adequate research questions. Again the truth may be somewhere in the middle.

The examiners and their feedback

Validity could be improved and assessment made fairer by increasing the number of examiners and rendering their approach uniform. Videotapes of the clinical interview and the examination situation could be used for feedback. They could also serve to settle cases of appeal in the event of failure.

Examinations only exist because there are willing examinees. Since they start the ball rolling by applying to be tested, it must be right to inform them of their performance. Written and audio-visual recording would secure adequate feedback. It is less clear who would pass on this information. For example the Chief of Examiner's office could take over this responsibility and communicate directly with the candidate. Alternatively, it could channel the information through the psychiatric tutors.

Final comment

The debate must continue. Whether *de facto* or *de jure*, examinations have functions other than separating the grain from the chaff. They create habits, educate and set traditions. Like the *Journal*, they not only 'reflect' rank and file feeling but influence the way the specialty goes. For example, the current MRCPsych examinations contain fewer questions on general medicine and neurology than the old DPM. According to taste, this may be a good or a bad thing. The point, however, is that, repeated year after year, this bias imposes upon the trainee a particular view of psychiatry.

It is peremptory that these basic points be considered in all further debates for, as the Dean, Dr Birley, said: 'The Membership Examination affects us all for good or ill'. Professor Cawley's exhortation that all interested members should write directly to him must be heeded. For once all is said and done we shall end up with the examination we deserve. But then it would be too late to complain.

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