irrational issues, and this serves the purpose of protecting the clientèle from being the focus around which staff problems are played out.

It seems right to me that the psychiatrist's role in this kind of situation should be largely defined in terms of what he does not do. In principle, if there isn't any trouble, he should not have a job! Psychiatrists of experience are extremely expensive personnel, and it is surely vitally important that they do not become engaged in carrying out duties that can be managed perfectly well by less experienced, less highly trained and less expensive personnel. I sometimes think of my work as being like that of being a pretty tough football in a football match; for those who wish to observe and to know what is going on, there is much to be learned by watching the particular direction in which I am being kicked at any particular time!

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A COMPARISON OF PSYCHIATRIC EXAMINATIONS IN THE UNITED STATES AND CANADA

By Joseph Berger

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Some years ago, I wrote an article about psychiatric residency training in the United States.[1] As my own experiences on making enquiries in England had been that very few people knew what went on or was available in the US. I felt that it might help those who were contemplating taking some or all of their postgraduate training there. Also, that it might be helpful to those wanting to make some comparisons between the training they were receiving in England and that available in the US.

In both Canada and the United States, certification examinations are taken at the *end* of training, unlike the M.R.C.P. for example which is almost an admission requirement to *commence* specialty training. Indeed, eligibility for the oral part of the American Board exam requires *two years* of work *after completion of training*.

At the present time there is a significant difference between Canada and the United States. In Canada, the F.R.C.P.(C) or certification examination pass is virtually a necessity to practise as a psychiatrist, indeed it is a legal requirement in some provinces. In the major cities of Canada therefore, with the exception of a few psychotherapists or psychoanalysts, any practitioner of repute in private or university practice would have certification.

By contrast, in the United States, Board Certification, the DABPN, is not a necessity at the present time. Anyone can call himself or herself a psychiatrist and open an office as such. In the psychiatric community, until recently, completion of an approved residency training at a centre with a good reputation was sufficient for initial acceptance, even a university faculty (part-time) appointment, and Board certification was a sort of luxury, often associated with those who aspired towards full-time academic careers.

In recent years, this situation has changed in the United States. There is a widespread feeling that the country is moving towards some form of universal health insurance, and already medical insurance coverage of a variety of forms is spreading. With such increases, whether governmental or non-governmental insurances, come increased requirements for accreditation and accountability. In practical terms this means that payments are being made, or are going to be made, only to legitimately designated practitioners, and different payments will be made according to different levels of practitioner as measured in *objective* terms.

Consequently, in recent years there has been an enormous increase in the numbers of doctors taking the specialty board examinations, and this is particularly true of psychiatry.

Nevertheless, the difference still remains, that is that the Canadian *has* to take (and pass) the boards; the American is still taking them out of choice, not necessity.

A major consequence of this difference is[2] that there is much greater pressure on the Canadian examination candidates. Study groups are set up 1½ years or more before the examinations; candidates take mock examinations, practise orals, write essays, for months before, and their training programmes are very much examination oriented.

By contrast, the American candidates for the most part have spent perhaps a few months in a general

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revision of basic material. Their written examination consists only of multiple-choice, so they do not have to practise essay writing. As many are already in private practice, they believe that they are practising their interviewing skills on a daily basis, and therefore ask colleagues or former teachers much less frequently to supervise practice interviews before the exam.

The anxiety generated by the Canadian examination seems much higher than that generated by the American examination, which arouses anxiety mainly restricted to the situation itself, that is, performing before an assessor, demonstrating one's competence or lack of it in one's field of work before another who is going to say whether the candidate is good at it or not, and in the written part, whether the candidate has acquired the minimal amount of basic knowledge necessary to pass. In the Canadian examination, the anxiety is much wider, for the candidate's career, future earnings, domicile perhaps, immediate job prospects certainly, depend on passing the examination.

What of the examinations themselves? At present, the Canadian examination consists of a written part comprising an essay section, and a multiple-choice section. Passing the written part entitles the candidate to attempt the oral part two or three months later. The oral part consists of a 1 hour interview with a patient in the presence of one examiner, followed by an hour of questioning on the patient and other matters by that examiner plus a second examiner.

The Canadian multiple-choice examination has come under criticism in the past for being too heavily basic-science oriented. Its questions in the areas of psychodynamics and psychotherapy were often poorly chosen or poorly worded. The American multiple-choice seems more relevant. It consists of two parts, one entirely on psychiatry, the other including a large neurology section, and passing the multiple-choice part entitles the candidate to enter part 2, the oral examination, when eligible. Since the mid-1970's, the written part has been eligible for entry on completion of residency training, three years, while a five year eligibility period is necessary for the oral, the rationale, aside from any logistics and manpower questions, being that the written examination tests basic fundamental material, best tested during or at the end of an accredited training period. The oral is meant to test clinical skills; these should be concentrated on by the maturing clinician, and a clinical examination is no longer the place to test text-book knowledge. This fundamental difference in approach has considerable significance in my opinion, for the practice of psychiatry in the United States, and in Canada.

In the American multiple-choice examination, questions are asked that are either of basic theoretical-knowledge importance, or are clinically relevant. An example I remember related to 'The patient waits till almost the end of the session to bring up material that the patient says is very important and significant, what do you do?' and various choices are offered such as prolonging the session, inquiring why the patient waited till near the end of the session, suggesting the patient bring it up on the next occasion, etc. This was an example of a clinical situation that most practitioners, be they biologically or psychoanalytically oriented, must have come across many times.

The neurology questions in the American multiple-choice provided little difficulty for candidates who had taken some interest in their neurology work in training. No attempts were made to cheat or trick candidates, and the material was relevant to the clinical difficulties that might be encountered by a general psychiatrist working in the areas where psychiatry and neurology overlap.

The Canadian oral examination consists of the one interview plus questioning. It seems that the pool of examiners for the Canadian examination is a rather small pool, limited in that it is almost entirely university-based, and highly variable in quality. The American examiners are drawn from a much wider pool and include many involved in private practice. The attitude of the American examiners on the whole seems warmer and more courteous.

This difference seems to stem from a major divergence in outlook. In Canada, the candidate is seen as a *student*, and this examination will determine whether or not he or she becomes a graduate, while in the United States, the candidate is a *colleague*, often an older and indeed sometimes more distinguished colleague, but even if younger, still a colleague.

Until recently, the American oral examination consisted of two interviews of half an hour each, with different patients, followed in each case by a half-hour of questioning on that patient. Recently, one of the live patient interviews has been replaced by the showing of an audio-visual film of an interview with a patient lasting about 20–25 minutes, and then the candidate goes with the examiner or examiners to a room and is questioned till the end of the hour, on the tape material.

The opportunity for two different patient interviews in the past obviously provided candidates with the chance to make up for a poor interview the first time, yet experienced examiners point out that a few minutes is usually sufficient to separate the competent clinicians from the incompetent ones. The really simple and basic things that the examiners in the

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American Board examination are looking for clinically, in terms of putting the patient at ease, relating to the patient, letting the patient tell a story, and establishing briefly and clearly the mental state of the patient, are covered well even in a short time by naturally anxious yet competent candidates, and not covered well by less competent candidates.

What are some of the results of the differences in these examinations? At the examination level, the candidate for the Canadian examination presents material in a way superior to that of most American candidates. Furthermore, I feel that the good Canadian examination candidate has a wider knowledge of the basic sciences, and of the psychiatric literature. However, the Canadian candidate usually has less understanding of what is actually happening with the patient. While the Canadian examiner has started asking questions about barbiturate interactions, the American examiner is concerned to hear from each candidate what would happen in the treatment of the patient seen (live, or on tape), whatever type of treatment, biological or psychotherapeutic, is undertaken. The better American candidates were able to deal with these issues competently, even on the basis of a shorter interview (20 minutes film, 30 live).

The average Canadian candidate, however, who has just finished training, having been geared almost totally towards passing an examination, and with rare exceptions having almost no *worthwhile* training and supervision in psychodynamic psychiatry, would have difficulty surviving a few days in an office practice of predominantly psychoanalytically-oriented psychotherapy. Putting it another way, the Canadian 'graduate' is able to 'consult', he can write a long dissertation on a chart, often quoting from the literature, discuss the history, examination, diagnosis, and prescribe what *someone else* should do, or *what should be done*, to treat this patient. But other than prescribe drugs, or press a button, most might be regarded as inadequate to treat the patient themselves. The American candidate of good quality (and it must be admitted that the larger numbers of candidates have provoked the examiners into much soul-searching about the quality of candidates they are passing) can relate to, and treat, emotionally distressed human beings.

The psychiatrist in office practice may not make much reference to the literature in a consultation note, but there does appear to be a feeling of competence to be able to work with the patient, which some people still feel is the primary goal of medical practice, and therefore what specialty board examinations should really be testing.

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HOW TO STOP WORRYING ABOUT MULTIPLE-CHOICE QUESTIONS

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I believe it was Charles Kaleb Colton who wrote that: 'Examinations are formidable even to the best prepared, for the greatest fool may ask more than the wisest man can answer.' Few statements are both so true and so comforting to the examination candidate, and so usefully cautionary for the examiner.

Multiple-Choice Questions (MCQ's) are a technique that can provide a reasonably reliable measure of knowledge, reducing the effects of examiner idiosyncrasy. They are intended to produce results that are influenced only by those factors they are designed to test; results that depend on your knowledge of the subject itself rather than your knowledge of the examiner, or your social or linguistic graces. They are more fair to more candidates than other readily available ways of assessing knowledge, less ambiguous and more reproducible. Unlike other techniques, it is easy for MCQ papers to be marked automatically—and their results can be computer-analysed not only to assess the candidate but to assess the examination itself, and to identify and reject ambiguous or unfair questions.

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