Why trainees fail mock MRCPsych clinical examinations

A personal view

Peter Donnelly

The clinical examination is the cornerstone of the MRCPsych Parts I and II. Trainees frequently prepare for the clinical by practising in a mock examination setting. One person's experience in examining candidates in mock clinical examinations is reported and an approach to the clinical examination is described. Some of the common pitfalls are highlighted.

The introduction of the MRCPsych Part I in 1987 has put more emphasis on the clinical examination. One of the reasons for the change was to try and ensure a high standard of history taking and examination of the mental state at an early point in a trainee's career.

As a post-membership registrar, a senior registrar and now a consultant, I have been involved in examining trainees in over 200 mock examination settings in different psychiatric units in England and Wales. The College sends trainees useful but limited feedback if they are unsuccessful in the examination. It may be helpful to hear in more detail why candidates have failed mock examinations. These views are my own but also stem from discussions with senior registrars, consultants, current College examiners and ex-examiners.

There has been little written about the reasons for failure at the clinical examination. Macaskill & Wood (1989) highlighted their experience as examiners in the Part I. The most frequent errors in their view were failure to make a systematic assessment of the risk of suicide and inadequate basic descriptive psychopathology.

General considerations

Even in a mock examination setting, most candidates are nervous. Some overt anxiety is acceptable and expected but the Yerks–Dodson law applies, that is if anxiety continues to increase there comes a point when performance declines.

Candidates should be neatly dressed but there are no strict rules about attire. A dark blazer and trousers are not mandatory for men and nor is a dark 'formal' outfit essential for women.

Brief description of the patient and the clinical problem

The first two to three minutes are vitally important. First impressions can be lasting. Candidates lose points at this stage by being vague and hesitant or even forgetting the patient's name. The description of the clinical problem (or presenting complaint) should be concise and without repetition. If a patient is now in remission candidates should state this and describe briefly the last episode of illness or admission.

Factual information on history

Each patient is an individual with a different life history. A candidate who omits questions may miss important facts. For example, a candidate who fails to ask about the past medical history may miss the fact that the patient has temporal lobe epilepsy following a head injury.

https://doi.org/10.1192/pb.19.5.302 Published online by Cambridge University Press

Mental state examination

One of the commonest mistakes is to confuse the presenting complaint with the current mental state. When presenting the mental state examination, it is 'the patient's mental state when I interviewed him or her'. Another mistake is to confuse the patient's current mental state with the mental state at some time in the past.

As Macaskill & Wood (1989) have indicated, incompetence with basic descriptive psychopathology can fail a candidate. The use of non-technical language and misclassification of phenomena correctly elicited is not infrequent.

There is no fixed scheme for presenting the mental state but it does need to be comprehensive.

Observing the candidate interviewing the patient

The commonest mistake is failure to elicit basic descriptive psychopathology. This applies particularly to psychotic symptoms. Candidates often do not investigate symptoms adequately, failing to follow up a basic stem question with additional questions to help clarify the phenomenon.

A candidate may be asked to elicit specific psychopathology during the interview with the patient. It can be a difficult task to balance eliciting information and maintaining rapport. If the patient is distressed then the candidate should 'back off'. The examiners are interested in the candidate's basic clinical skills including the ability to interview difficult or reluctant patients.

Differential diagnosis

A common failing is not to connect the presenting complaint, mental state examination and differential diagnosis. If the patient's history and mental state suggest a depressive illness, the candidate must communicate this to the examiners. Too often, trainees regurgitate a list of possible diagnoses without mentioning the pros and cons of each one. It can be useful to say, "Based on my assessment so far, the most likely diagnosis is Y but I would also like to exclude A, B and C. The evidence for Y is this and that but against it is ...".

Aetiology

Often trainees fail to be systematic in their assessment of possible aetiological factors. The recent College notes for guidance have clarified the situation. A useful approach is to consider predisposing, precipitating and perpetuating factors. Within each of these areas the candidate should consider social, psychological and physical factors.

Trainees sometimes feel concerned about the psychodynamic aspects of assessment. If a case has an obvious psychodynamic element, e.g. depressive symptoms starting two months after the death of the spouse, then it would be sensible to bring up the 'loss of a significant person'. Points that might be covered in a cognitive/behavioural or psychodynamic assessment are described in the College notes.

Physical examination

The recent statement by the College clarifies the place of the physical assessment which is now considered mandatory. If time or other constraints prevent a complete examination the candidate must be prepared to justify this.

Further information

Good clinical practice includes clarifying the patient's history with a corroborative history from a reliable informant. In an examination setting it is worth candidates telling the examiner that they would like further information. A candidate should be prepared to go into detail about what information might be relevant and why it would be helpful to gather it.

Management

The main difference between Part I and Part II of the MRCPsych is the emphasis in the Part II on management. Examiners frequently 'mark down' candidates for not taking a systematic approach. For example, some candidates will focus on drug treatment without emphasising the importance of further assessment, corroborative histories and developing a therapeutic relationship with the patient. Candidates can look at management in relation to immediate (e.g. "this patient should remain an in-patient because....") intermediate and long-term plans.

One principle I find useful is that of 'giving it all' to the examiners. For example, instead of

https://doi.org/10.1192/pb.19.5.302 Published online by Cambridge University Press

saying "I would use chlorpromazine", answer "I would prescribe the aliphatic phenothiazine chlorpromazine initially at a dose of 50 mg QDS and titre the dose according to clinical reponse and side effects. I would use chlorpromazine in this patient particularly for its sedative side effects. ..."

'Never say ...'

The 'never say syndrome' has haunted medicine and its associated examinations since the time of Hippocrates. To my knowledge, trainees have been told 'never' to say four terms in the examination setting.

Personality disorder

The rationale behind never mentioning this in the differential diagnosis is that after only a one hour interview, it is impossible to decide if the patient is describing factors that are enduring, long-standing, and not limited to episodes of illness (WHO, 1992). However if a personality disorder is the most likely diagnosis the candidate should give it. It is reasonable to qualify the diagnosis stating "it is difficult to label a patient with this diagnosis after only one interview, and a corroborative history from an independent historian is essential".

Schizoaffective disorder

Many trainees avoid this term, having been told it "does not exist". It is better to consider schizoaffective disorder as a controversial diagnosis. If candidates can argue about the pros and cons of the diagnosis they can use valuable time showing the examiners their knowledge of the issue (Brockington & Meltzer, 1983).

Paraphrenia

This is perhaps less controversial but trainees still sometimes hesitate to use it. As with schizoaffective disorder, if the clinical picture fits it is reasonable to use the diagnosis (Holden, 1987).

Hysteria

The term 'hysteria' *per se* is probably best avoided as it appears in many contexts (Kendell, 1982). In ICD–10 and DSM–IV, the term 'dissociative disorder' has been used to replace hysteria and will be preferred by most examiners.

'The predicament'

Many trainees express concern over the question of which classification system to use, ICD–9, ICD–10 or DSM–IV. The recent statement from the Chief Examiner (Mann, 1993) clarifies the situation with candidates expected to be familiar with ICD–9, but with a gradual transition to ICD–10 since April 1994. In my experience, candidates do poorly if they use non-technical or layman's terms outside of any classification system. At that point, an examiner may ask the candidate to clarify the diagnosis which can create a bad impression.

Candidates often worry that by making one mistake, they will fail the examination. In my experience, this is generally not the case. The College instructs examiners to give the candidates an overall mark. This tends to reflect more of a general impression made by the candidate. Clarity in the style of presentation and the ability and knowledge to discuss the pros and cons of the differential diagnosis or difficulties with a particular part of the assessment can help pass the candidate.

I hope these observations may help future candidates prepare for and be successful in the clinical examination.

Acknowledgements

I thank Dr Rosalind Ramsay for her helpful comments, and Mrs D. Donnelly for her help.

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