Would candidates, randomly-chosen or in whole cohorts, accept, over and above the examination, a test of their emotional state? What test would be acceptable, reliable and valid as a measure of disabling anxiety rather than inevitable or useful arousal? Should it be applied before or after the candidate has been examined, and how long before or after? Precisely what questions would it answer? Should we not prefer to concentrate on finding ways of reducing excessive anxiety; if so how can we go about this?

The matter of 'Examination techniques', Dr Azuonye's next point, provides a challenge to the examination and the examiners as well as to the educators responsible for helping the candidate to prepare for the event. How important is 'technique' in an examination which aims to be as fair a test as possible of the candidate's knowledge and competence? The necessary skills for display of knowledge and competence should not be recondite. Yet they seem to be important enough to be learned and taught. Opportunities for rehearsal with senior colleagues are bound to be useful.

In his final point Dr Azuonye imputes grossly unethical behaviour to the examiners. Would such disagreeable men and women be honest in their self-report? We will look into it as soon as Dr Azuonye supplies grounds for his allegation.

R. H. CAWLEY
Chief Examiner

DEAR SIRS

Dr Azuonye is partially correct in his assumption that one of the aims of the 1985 Trainees Forum was to 'pinpoint' reasons for a higher failure rate in the MRCPsych for overseas graduates having first established that it was indeed the case. There were, however, other aims of a less ambitious kind such as highlighting the problem and providing some facts upon which reasoned argument could then be based.

The survey by Professor Cawley, in spite of its detailed analysis, revealed no consistent cause in the discrepancy in pass rates. There was no part of either examination that caused significantly more failures in overseas graduates. It is difficult to determine how to test Dr Azuonye's hypotheses (a), (b), (c) and (e) further since another measurement or examination of these abilities would be needed which was also independent of the MRCPsych examination. Which would be the more valid?

Professor Cawley, in his letter, has pointed out the problems of assessing anxiety and self-doubt in examination candidates. Regarding the final hypothesis of discrimination, this would be even more difficult to assess, as Professor Cawley has pointed out. It is something that the CTC is sensitive to, although the Dean has not found any evidence of its occurrence[1,2]. The College is aware that it must be seen to be against discrimination as well as actually being so. The College has recently agreed to questions regarding 'Nationality' and 'Place of Birth' being removed from the Examination application form.

The one hypothesis that Dr Azuonye does not mention is that success at the MRCPsych may be partially determined by place of training. It was the hope of the CTC Working Party that when the College computer was installed future monitoring of the Examination would include analysis of this variable, even if it would not be possible to control for all other variables.

The CTC Working Party also made some recommendations[2] regarding interviewing skills, examination techniques and feedback which it believed were important in any attempt to alter the discrepancy in pass rates. The CTC hopes that these recommendations will be considered carefully by clinical tutors and MRCPsych Course Organisers as well as being brought to their attention by local trainees. The Central Approval Panel has already recommended the provision of interviewing skills training in basic professional training. It has also agreed that visiting teams should ask what help and advice is offered to trainees who fail the Examination.

PETER WHITE
Chairman, Collegiate Trainees Committee

REFERENCES

[1] BIRLEY, J. L. T. (1986) Performance of foreign candidates at the MRCPsych examinations. *Bulletin of the Royal College of Psychiatrists*, **10**, 54–55.

[2] WHITE, PETER (1986) Why do overseas trainees fail? *Bulletin of the Royal College of Psychiatrists*, **10**, 59–60

The HAS—the quango's defence

DEAR SIRS

A number of points arise from the response of Dr P. Horrocks (*Bulletin*, June 1986, **10**, 145–146) to recent criticisms of the *modus operandi* of the HAS:

(i) In common with members of the Mental Health Commission, the Director believes himself to have access to special sources of wisdom concerning the nature of 'good practice'. Apparently it is possible to pass this knowledge on, or at least to select for such knowledge, and thus to ensure that 'the constitution of the visiting teams ..... continuously reflect current perceptions of good practice' (p. 146, and also p. 146 HAS teams 'are far too experienced' to be misled by 'unsubstantiated' opinions concerning service provision).

(ii) This knowledge does not come from research. 'To comment on other areas, such as research, would not be our responsibility .....'. One appreciates that there may be a difficulty in assimilating research findings with received wisdom from the more customary sources. It is salutory that the Director has confirmed that no contamination of the latter by the former is allowed to take place.

(iii) The costs of the exercise are not inconsiderable. £5,000 per health district per year presumably means 1.5 to 2 million pounds a year for the country as a whole. This takes no account of the disruption of services (and even dissension) caused by an HAS visit.

(iv) In spite of his repeated protestations to the contrary the Director's predilection for particular types of psychiatric management cannot be concealed. Thus 'traditional psychiatry' is 'facing a challenge' and 'must no longer be bounded by the hospital perimeter but reach out possibly to treat and support most of its patients close to their homes'.

Psychiatry is 'a rapidly evolving specialty' and psychiatrists 'should adopt more locally directed responsibilities'. Presumably it is for these reasons that community psychiatric nurses are so favoured and out-patient clinics viewed with suspicion. The notion that psychiatric illness can be prevented by staff travelling around in cars in larger numbers and more frequently is a profound one, but it is not insusceptible to investigation.

(v) There is an inquisitorial aspect to the Director's attitudes. Thus 'it is no longer the privilege of authorities to cloak the shortcomings of their services in secrecy' and 'Those who call for (the) abolition (of the HAS) [i.e. ourselves] ... might wish to speculate on the potential acceptability of the replacement inspectorate which would undoubtedly by imposed instead'.

We have noted these opinions with interest. We urge any psychiatrist who is invited by Dr Horrocks to become part of an HAS team to read this exchange of views before coming to a decision.

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Bridges over Troubled Waters

DEAR SIRS

I am writing to you as Chairman of the Association for Psychoanalytic Psychotherapy in the National Health Service, an association with a membership of some 200 professional staff of all disciplines in the NHS. Our Council has recently been considering the report of the Hospital Advisory Service called *Bridges over Troubled Waters*, which deals with services for disturbed adolescents.

There is much to commend in this Report, notably the emphasis on the importance of organisation and integration of adolescent services. There is certainly a need to plan and organise services in a more coherent and integrated way and this is quite unexceptionable. However, we have found deficiences in the report so glaring that it would be a grave disservice to the needs of this group of patients were it permitted to proceed unchallenged, possibly to become a blueprint for a future national service.

We think this is a very biased Report and some of this bias may arise from the membership of the Steering Committee which produced it. This Committee included two nurses and two social workers but only one psychiatrist, and could not be expected to represent the varied approaches to adolescent problems which exist in adolescent psychiatry. There was no child psychiatrist on the Steering Committee which is surprising in view of the fact that it is child psychiatrists who treat the majority of patients up to the age of 18, especially of out-patients. Obviously only a small proportion of adolescents who need treatment are admitted to residential units.

There was no psychotherapist of any colour on the Steering Committee and certainly no-one who could represent the psychoanalytic approach. This too is most surprising in view of the fact that most of psychiatrically disturbed adolescents present problems that are not amenable to physical methods or behavioural approaches.

It is probably a reflection of the membership of the Steering Committee that the Report does not contain the word 'psychotherapy' in any of its 77 pages. The closest it comes to a mention of psychotherapy is in paragraph 4.24 where it says "some of the adolescents felt the lack of 'someone to trust'. A confidante type of support worker not attached to any service who would listen and not pass information on to parents or other workers would fulfil a very important role for young people who often felt they had no-one". The provision of psychotherapy for all age-groups in the NHS is clearly grossly deficient and we consider this Report to be negligent in not drawing attention to this lack as far as adolescents are concerned. We believe that it is not simply a support worker, but a trained psychotherapist that adolescents need as part of the team concerned with their psychiatric care.

In our opinion an even more serious criticism of the Report is the view that it presents of adolescent disturbance as something that arises out of the blue during teenage years. There is no indication of any understanding of the antecedents of adolescent disturbance. The majority of disturbed young people have a history of emotional problems at earlier ages and every child psychiatrist is only too aware how often the disturbance has been overlooked. There is absolutely no mention in the Report of the importance of child psychiatric services preventing disturbance during adolescence or at an even later age.

We also think the report is unrealistic and misguided in its recommendation that every adolescent unit should have an eclectic approach. To expect every adolescent unit to provide a total psychiatric service flies in the face of common experience which has taught us that units which admit to being eclectic commonly fall between every possible stool, whilst units that have a more coherent approach tend to be more successful. We are in complete agreement that every Regional Health Authority should aim to provide a "total psychiatric service" but it is quite unrealistic to expect every specific unit to provide one.

We are not seeking to promote psychoanalytic psychotherapy as the sole method of treating adolescents. But we do believe that psychotherapy is important in helping a disturbed adolescent come to terms with himself and that the provision of psychotherapy should be a central part of any plan for adolescent services. Moreover we believe that psychoanalytically-informed psychotherapists can also help staff members cope with the difficult tensions which arise in an adolescent unit.

Finally, the appendix to the Report lists organisations and individuals who have provided oral or written evidence to the Committee. This gives the impression that these organisations support the conclusions of the Report and we have found this is very far from the truth. Many of those listed have already expressed serious differences and object to the whole tenor and conclusions of the Report.

Association for Psychoanalytic Psychotherapy in the NHS JOHN STEINER *Chairman*