The performance of the examination is closely monitored by the Royal College of Psychiatrists' Examinations Sub-Committee with robust quality assurance processes in place. The content and performance of each item is scrutinised pre- and post-examination. The College is also required to provide data and reports to the regulator (the General Medical Council, GMC) and any proposed changes to the examination require GMC's approval. Recent changes approved by the GMC include a reduction from three written papers to two (introduced from this year) and a change to the CASC marking scheme from the Hofstee method to borderline regression (from diet 2 this year). As part of the process to reduce the number of written papers, the written paper question banks have been fully reviewed and updated. The statement that MCQs are continuously recycled year after year is incorrect. New questions are constantly being developed and every examination paper has about 40% of new questions. All questions have been mapped to the examinations syllabus and new question writing is focused on areas of the question bank where the range of questions is limited. There is also a focus on developing a greater range of questions testing clinical management within Paper B.

The MRCPsych examination is under continuous review and development by the Examinations Sub-Committee. An external review of the examinations was commissioned in 2014 and we are following up on recommendations for further enhancements to the MRCPsych. These are due to be published at the end of 2015.

The curriculum, like the examination, is under constant review in a process that involves a wide community including lay people, trainees, medical managers, psychiatry experts and trainers. All changes have to be approved by the GMC and there is regular dialogue between the College and the GMC. A major revision of the core curriculum is being planned and will include the incorporation of the examination syllabus.

While we understand that trainees may feel the MRCPsych is another hurdle, ultimately, the College is responsible for ensuring that quality and patient safety are at the forefront of its examination processes. We are satisfied that the current standard is appropriate for entry into higher training. While it is our ambition to drive up the standard, we are aware that a significant proportion of core trainees struggle to achieve the standards set by the examination. The College is keen to influence training and the learning experience of trainees. To this end we have introduced Trainees Online (TrOn; http://tron.rcpsych.ac.uk), a series of online learning modules for trainees that will eventually cover the whole MRCPsych examination syllabus. We have also been working with MRCPsych course organisers to improve the standard and consistency of courses. We hope that increased clarity about what trainees need to know will lead to higher examination pass rates as well as the acquisition of knowledge that will support clinical practice.

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Psychiatry is more than neuropsychiatry

In his editorial, Fitzgerald[1] rehashes the well-trodden arguments for the reunification of neurology and psychiatry, suggesting the time has finally come. What he fails to address is that the trend in every sphere of medicine is towards further specialisation and not integration. Why psychiatry and neurology should be the exception to the rule goes unanswered.

It is only ever academic psychiatrists, appearing out of touch with clinical practice, who propose that psychiatry has advanced to the point where it is indistinguishable from neurology. On the contrary, despite the calls for psychiatry to become a clinical neuroscience discipline,[2] psychiatric practice has remained untouched by developments in neuroscience. To be sure, neuroscience is a core basic science for psychiatry. But the claims that psychiatric disorders are simply brain disorders, or that our observations or interventions are not worth a jot if not based in neuroscience, are part of a creeping trend towards neuroessentialism in every sphere of life.[3] Psychiatrists do not simply deal with brain disorders – to claim otherwise is to impoverish our field. Psychiatry is at its best when embracing a pluralistic approach to the disparate range of problems that fall under our gaze. To neglect insights from the psychological, sociological and anthropological sciences and the narrative approach to formulation does a disservice to our patients. The patient who becomes suicidal after a relationship breakdown and the patient who becomes panic-stricken and housebound after a rape do not have problems that can be made sense of in the same way as the patient with visual hallucinations and bradykinesia, or the patient with impulse control problems after a brain injury. Put simply, even if we accept the claim that psychiatric problems are brain disorders, many problems can be effectively treated without thinking about the brain.

Psychiatrists could certainly benefit from a stronger training in clinical neuroscience and neurology in general, and neuropsychiatry and behavioural neurology in particular. But as Alwyn Lishman said, 'You have got to have a finger in every pie in psychiatry and be ready to turn your hand to whatever is the most important avenue: an EEG one day, a bit of talking about a dream another day. You just follow your nose. All psychiatrists should be all types of psychiatrist'.[4] I could not agree more.

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1 Fitzgerald M. Do psychiatry and neurology need a close partnership or a merger? *BJPsych Bull* 2015; **39**: 105–7.

2 Insel TR, Quirion R. Psychiatry as a clinical neuroscience discipline. *JAMA* 2005; **294**: 2221–4.

3 Reiner PB. The Rise of Neuroessentialism. In *The Oxford Handbook of Neuroethics* (eds J Iles, B Sahakian): 161–75. Oxford University Press, 2011.

4 Poole NA. Interview with Professor William Alwyn Lishman. *Psychiatrist* 2013; **37**: 343–4.

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A more practicel solution is needed

Professor Fitzgerald is worried about the serious recruitment crisis in psychiatry. His answer is to advise psychiatrists to abandon their specialty and 'return home to neurology'. In his opinion, a merger of the two professions would encourage clinicians to focus on careful clinical analysis and diagnosis,

reduce professional isolation and stigma, enhance status and so improve recruitment. This may or may not be true, but I wonder about the attitude of neurologists to his proposal. The working life of a general adult psychiatrist is not easy and I think neurologists are likely to resist his advances. I don't know many who would be willing to regularly attend community-based mental health act assessments in inconvenient circumstances, subject themselves to cross-examination by enthusiastic lawyers in front of their patients at mental health tribunals, defend their practice at critical legalistic external inquiries, or subject themselves to the restrictions imposed by 'new ways of working'. Psychiatric practice certainly needs to be reformed but a more practical analysis of our problems is urgently required. In my opinion, our College must lead on these issues. If it continues to equivocate it will quickly become an irrelevance.

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1 Fitzgerald M. Do psychiatry and neurology need a close partnership or a merger? *BJPsych Bull* 2015; **39**: 105–7.

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Can psychiatry and neurology 'simply' merge?

I appreciate Professor Fitzgerald's citation of my 2005 article, titled 'Why psychiatry and neurology cannot simply merge',[1,2] however, he seems to have misconstrued the essential nature of my argument. He positions his discussion of my article just after the statement, 'The chorus of disapproval against neuropsychiatry has certainly grown'. But I would like to assure Professor Fitzgerald that I am not, nor have I ever been, part of such a 'chorus'. A careful reading of my article will show that the key word in my argument is 'simply'. I am not opposed in any way to integrating neurology and psychiatry; rather, I argue that certain types of 'bridging' concepts and constructs would be necessary to bring about such a union.

I describe neuropsychiatry as 'a vitally important transitional stage in the development of brain science'. Indeed, I would argue that neuropsychiatry is the crucible within which the discourses of psychiatry and neurology will eventually 'bond', producing a narrative that incorporates the dialectical and subtextual understanding of psychiatry into the framework of neurophysiology and neuropathology. But until such a meta-narrative has evolved, there cannot be a genuine merger of psychiatry and neurology. Or rather, we should say that without such a meta-narrative, the nature of the merger would be more like the grafting of an oak branch onto a maple tree than the hybridisation of two varieties of rose.[2]

I fully agree with Professor Fitzgerald that 'the separation of neurology from psychiatry has led to a separation of the brain from the mind – the physical from the mental – which has been unhelpful for both disciplines'. That said, I do not accept the view that psychiatric disease is best described as 'brain disease' or that mental constructs are 'reducible' to mere physiological or neuroanatomical terms. But this is a complicated philosophical issue best left for a longer communication.[3]

Stated briefly, I believe that 'disease' is most usefully predicated of persons, not minds or brains, and that there are ways in which a union of neurology and psychiatry could contribute to a very rich understanding of the human person, and how personhood is undermined and compromised by disease states like schizophrenia.[4]

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1 Fitzgerald M. Do psychiatry and neurology need a close partnership or a merger? *BJPsych Bull* 2015; **39**: 105–7.

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3 Pies R. Mind-language in the age of the brain: is "mental illness" a useful term? *J Psychiatr Pract* 2015; **21**: 79–83.

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Fully inform the Martian

At first glance, Reilly's thesis appears reasoned and structured.[1] But his argument is flawed, such that he misses the most important reason for the distinction between psychiatry and neurology, with which a Martian would surely concur.

Reilly states that 'most organs (such as lungs, kidneys, hearts and eyes) are treated by a single medical specialty'. Not so. A cardiac surgeon operates on the heart, determines which patients would benefit from surgery, and manages pre- and post-operative care. A cardiologist's talents lie elsewhere.

Similarly, the division between psychiatry and neurology is defined by knowledge and skill. This is no artificial distinction imposed by a quirk of history, but reflects a difference in the very nature of the knowledge and skill base developed by doctors as they specialise. One cannot expect every trainee neurologist to additionally become expert in, say, holistic and developmental assessment, psychological formulation and complex diagnostic classifications of a nature unknown outside psychiatry. These are for trainee psychiatrists to focus on.

Doctors do not practise in isolation, but as members of multidisciplinary teams. Nurses and others develop similarly specialist knowledge and skills to work with patients with broadly different presentations.

Of course, there are small areas of overlap, but Reilly falsely dichotomises these to fuel his argument: I had no idea conversion disorder was the preserve of neurologists. At best, he puts forward a case for closer working and more shared care of patients between the two specialties. But two specialties they most assuredly are.

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1 Reilly TJ. The neurology–psychiatry divide: a thought experiment. *BJPsych Bull* 2015; **39**: 134–5.

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