Correspondence

Reading for the Membership: the value of a core book

DEAR SIRS

We note with interest the current debate on how to formulate cases for the MRCPsych examination. This is timely and long overdue. However, another area of concern to us is how trainees perform in the viva voce examination and more specifically how they 'read' for psychiatry. We have been holding 'mock' vivas for our candidates for the past four years and we have been struck at how often relatively simple questions concerning definitions, classification and basic epidemiology are mishandled by many of them. It is our belief that this is the result of faulty reading habits. The typical trainee coming up to the Membership examination will have read extensively, mostly from the College's Reading Lists. There will be much background information present, but at the viva candidates often stumble on such simple opening questions as 'How would you define obsessional neurosis?' or 'How common is schizophrenia?' Further elaboration of answers tends to show an unstructured organization of data.

To remedy this situation we would recommend trainees to get a short 'core' book at the outset of their careers, and over the next three years virtually learn this book off by heart. This would have several advantages:

1. At the start of one's career it would provide a good overview of psychiatry.
2. During the three years' basic training it is our impression that many trainees seem to lack an overall reading strategy. We feel their reading (at least 100 articles and chapters from the College's Reading Lists) should be built up around the core book. This is preferable to concentration on large textbooks of psychiatry which we feel should mostly be used for reference.
3. Coming close to the Membership it would avoid a not uncommon panic situation where a trainee says in despair: 'I've read a mountain of psychiatry, but I can't remember some of the simplest of things.'
4. At the Membership itself, as well as improving performance in the viva, the core book would also serve to improve performance in the essay paper. It would do this by providing a useful skeleton around which more extensive knowledge would be organized.

In short, we feel trainees should buy their core book at the start of their careers and not just as an aid to revision at the end.

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Reassessing the MRCPsych

DEAR SIRS

A number of correspondents recently made varied suggestions for the future of the MRCPsych Examination (*Bulletin*, October 1982, **6**, 170–6) which ranged from abolishing all or part of it (Dr Chris Thompson) to producing a 'marathon' exam, both for examinees and examiners, of many case reports and scrutinized interviews (Dr Mark Aveline). As someone who took the exam only two years ago, utilizing the research option, and who this year had opportunity to be an examiner for the first time in Part I, Final MB, I should like to make a few comments about the recent suggestions in the *Bulletin* and some personal suggestions for change.

Unfortunately, the only views backed up by any kind of survey or statistics were those of Professor Trethowan, despite the fact that these were invited views and therefore to be of some weight. In fact Dr Thompson tells us the views he expresses are not his own but just points for debate. Surely what the College needs are people's real views so that it can consider these and make a decision—I think we all know what the various alternatives are.

My colleagues and I feel that the exam should not be a final end to training but a gate to pass through on the way. Dr Aveline seems to accept this view but expresses concern that trainees may only have a few years' experience before sitting the exam. Surely this exam, like the MRCP, can only test that one has acquired some of the basic facts relevant to one's practice? No exam, whether in psychiatry, general medicine or other subject, can test *how* you carry out your work and, indeed, I feel that much of the 'how' and the 'clinical skills' are learnt in higher training as a senior registrar. I believe that training in any area of medicine is in large part an apprenticeship, with knowledge of the necessary skills acquired gradually. These skills are perhaps best assessed by those with whom the trainee has worked. Recently, in Belfast, Professor Fenton has introduced a scheme of regular six-monthly assessments by consultants of trainees (and by trainees of individual training posts). Perhaps this type of scheme might be extended. Though general practitioners are required to keep a log book of cases, as Dr Thompson points out, these are only minimal notes which may provide the basis for discussing a particular type of problem during a viva. It strikes me that the production of detailed case histories, as Dr Aveline suggests, may only tell examiners that a person is a good notekeeper and has a good theoretical knowledge. The validity of this as a method to assess clinical skills has not been proved. To test theoretical knowledge the MCQ appears to be the best instrument, as Professor Trethowan points out.

Again, the suggestion of scrutinized interviews may produce extra anxiety in many examinees. The assessment of

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clinical skills under such artificial conditions may not be valid or reliable.

The reliability of essays as part of the exam is questioned by Professor Trethowan. Drs Aveline and Thompson feel they have merit because they can test ability to communicate, ability to show critical judgement and test a wider area of knowledge. One surely must agree with Professor Trethowan that there are better ways to test the ability to communicate and this is not what the exam is for. He suggests a modification to a number of 'short-answer' questions. I should like to suggest a different type of replacement for the essay in Part II of the MRCPsych. The research option has been unpopular, and in my personal experience requires much more work than the small part of the exam it replaces. However, I feel that a valuable aspect of it is the encouragement to study a wider area of the literature on a specific topic and the encouragement to *think* about how a problem in psychiatry might be approached. I propose a modification of this option to a compulsory dissertation of, say, 5,000–7,000 words. This need not include any actual research work or results (though could if a candidate so wished) but would be an extensive review of an area of psychiatric literature of interest to that candidate, with reference to some unresolved problems in that area and perhaps suggestions as to how they might be tackled. In the instance of a candidate interested in psychotherapy or behaviour therapy, he or she might include a discussion of a particular form of therapy and illustrate this with a case or cases treated personally. The titles for such dissertations could, if it was felt necessary, be approved by either an examinations committee or the candidate's local Professor. I believe this type of innovation, instead of essay questions, would be the best way to test the ability to appreciate a wider area of knowledge and the ability to show critical judgement. In addition, it would be carried out in the absence of 'exam nerves', might stimulate people to think more clearly about problems and could stimulate research. For overseas candidates who may find the task of writing essays a greater task than others, it would allow more time for them to express themselves to the level of which they are really capable.

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Videotapes on psychiatric subjects

DEAR SIRS

Professors Seager and Goldberg (*Bulletin*, November 1982, **6**, 203–4) are to be commended for pioneering the use of videotape in training young psychiatrists to give ECT and for making their tapes available.

Inevitably these first productions are not wholly satisfactory and should be viewed critically. The Sheffield videotape is the better.

I am particularly concerned that the Manchester tape is offered for self-teaching for it contains errors of fact and technique. The tapes will be a useful aid to learning but not a substitute for full theoretical and practical training by those experienced in ECT. They ought to be discussed with learners when they are seen.

No doctor should administer the treatment unsupervised until the responsible consultant is satisfied with his knowledge and skill.

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DEAR SIRS

The recent flurry of publication, discussion and publicity has ensured that most doctors are alerted to the problem of alcoholism. Unfortunately some doctors, particularly those in training, are still unsure about what to do when confronted with a problem drinker. The result of this uncertainty is, not infrequently, frustration, irritation and despair for both the doctor and the patient.

The Department of Mental Health at the Queen's University, Belfast, has recently produced a new videotape, which is especially appropriate for use with medical students and junior medical staff, in either hospital or general practice.

The tape is called 'The Alcohol Dependence Syndrome—A Psychological Approach' (colour, 47 mins). It presents guidelines on the assessment of the problem and a model for understanding approaches (cognitive, psychodynamic and existential). The tape follows the progress of one young man through his time in the regional treatment centre, and deals realistically, but enthusiastically, with the often daunting process of rehabilitation.

The programme may be copied on to your own blank U-matic, VHS or Betamax cassette at a cost of £15. It is available from Mr Brian Patton, Audio-Visual Unit, Department of Mental Health, The Queen's University, Belfast, 97 Lisburn Road, Belfast.

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Psychology of nuclear disarmament

DEAR SIRS

I found Neill Simpson's letter (*Bulletin*, November 1982, **6**, 202–3) puzzling and on closer inspection disturbing in its form. The first paragraph sets an analogy, novel to me, between the deterrent effect of nuclear weapons and addiction to drugs, only to knock it down immediately. The second paragraph leads us from this analogy to a consideration of the fact that information is sometimes withheld from