columns

strengthening the ties already formed through organisations such as the European Forum for Psychiatric Trainees. In today's climate of a vast increase in mobility of the global medical workforce we would do well to pay heed to the needs of our prospective employers.

DAY, E., GRIMMER, C. & LLOYD, A. (2002) Psychiatry training in Europe: a brief history of the European Federation of Psychiatric Trainees. *Psychiatric Bulletin*, **26**, 152–154.

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What's in an MRCPsych!

There is such passionate debate going on about the award of MRCPsych without examination. Those who have struggled to achieve Membership through examination feel that the value of this has been somewhat lowered or tarnished. I was awarded Membership without examination and would like to share what this means to me and what advantages it has afforded.

Has it helped me to get a job, a promotion, or a higher salary? The answer is no. It is not even recognised in India as a qualification. MRCPsych has not conferred any advantage except receiving the *British Journal of Psychiatry* and the *Psychiatric Bulletin*. I definitely did not accept an International Fellowship because of a promise of MRCPsych and I do not mention it on my curriculum vitae.

To me it means the same as my other membership of international and national societies, all of which were awarded without examinations! There is no psychiatric society in the UK of which one can become a member except the College. If one could become a member of a professional body only through their own examination, it would be good neither for the professional nor for the professional body.

MRCPsych is an expensive membership to retain. For the annual fee one could get life membership or life fellowship of at least two or three Indian scientific societies. It is not surprising that some who are awarded an honorary MRCPsych are unable to retain it after some years. As far as I am aware, no International Fellow with Membership without examinations has secured a job in the Gulf or other countries where the Membership is acceptable. I am aware of quite a few with the honorary MRCPsych who have taken up assignments in different parts of the world or international organisations. It would be futile to speculate whether the honorary MRCPsych helped them to gain these positions.

I hope those opposing the award of MRCPsych without examination will view the process from the correct perspective and not feel that MRCPsych is some exalted object which they are being robbed of. I am happy to be a member of the College and enjoy participating in its activities, and will probably retain Membership as long as I can afford it!

Declaration of interest S.K.C. was awarded MRCPsych without examination under the International Fellowship Scheme in 2004.

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Referral of older adults with dementia, acetylcholinesterase inhibitors and the NICE guidelines

Drs O'Loughlin & Darley suggest that the rate of referral of older adults with dementia has increased since the launch of acetylcholinesterase inhibitors and the publication of the National Institute for Clinical Excellence (NICE) guidelines for their use (*Psychiatric Bulletin*, April 2006, **30**, 131–134). Although the authors acknowledged the limitations of their findings, there are serious ethical and practical objections to the conclusions drawn.

We are not clear whether the 42 000 people aged 65 years and over in the catchment area was for 1996 or 2003. Fluctuation in the size of this population could easily affect the referral rate. Moreover, the authors do not define criteria used for the diagnosis of dementia in either period.

Mini-Mental State Examination (MMSE) scores are dependent on the person administering the test, age and particularly education (Crum *et al*, 1993). The difference in the mean MMSE scores between the two groups reported by O'Loughlin & Darley is just 2.8. Other cognitive scales such as the Alzheimer's Disease Assessment Scale – Cognitive subscale (ADAS–COG) or Mini-Cog have greater reliability and validity (Borson *et al*, 2005).

Hence, unless the above have been satisfactorily answered, we cannot support the tentative conclusion that more patients are being referred earlier in the course of illness to old age psychiatric services following the launch of anticholinesterase inhibitors and publication of the NICE guidelines.

BORSON, S., SCANLAN, J. M., WATANABE, J., *et al* (2005) Simplifying detection of cognitive impairment: comparison of the Mini-Cog and Mini-Mental State Examination in a multiethnic sample. *Journal of the American Geriatric Society*, **53**, 871–874.

CRUM, R. M., ANTHONY, J. C., BASSETT, S. S., *et al* (1993) Population-based norms for the mini-mental state examination by age and educational level. *JAMA*, **269**, 2386–2391.

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Statistical assessment of MMSE scores

It is disappointing that the interesting study by O'Loughlin & Darley (*Psychiatric Bulletin*, April 2006, **30**, 131–134) was let down by the use of inappropriate statistics. Since scores on the Mini-Mental State Examination (MMSE) constitute data that are ordinal in nature, it is not appropriate for the mean to be presented as a measure of central tendency. For the same reason, it is not appropriate for standard deviation to be offered as a measure of dispersion. Use of the median and interquartile range (IQR) would have been more appropriate. Similarly, use of the *t*-test as a test for difference between the two groups was ill considered because MMSE scores in both study populations are negatively skewed. The authors should have used a non-parametric test for difference such as the Mann–Whitney *U*-test.

For the record, the median MMSE score was 20 (IQR 16–24) in the 1996 sample and 22 (IQR 19–25) in the 2003 sample. Running the authors' data through a Mann–Whitney test on StatCrunch (available at http://www.statcrunch.com) still finds a significant difference between the two groups (P=0.0037).

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Authors' reply The nature of pragmatic research is to examine clinical practice in the manner it happens – that is both its weakness (for example, not using research-standardised diagnostic interviews or detailed cognitive testing) and its strength. The MMSE has been in use in both clinical and research settings since 1975 as a tool for cognitive assessment and Drs Kripalani and Poongan are correct in stating the unreliability of a single cut-off point for any diagnosis. In our study we examined MMSE scores only of those patients with a diagnosis of dementia, and

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