Medical Visitors

DEAR SIRS

The Lord Chancellor's Department is shortly to advertise for a Medical Visitor to undertake special visits for the Court of Protection in the Principality of Wales. England and Wales is presently covered by five Visitors, appointed under S.102 of the Mental Health Act, 1983.

In 1982 the responsibility for interviewing and examining many cases was transferred to non-medically qualified civil servants. The LCD thereby saved a significant percentage of the costs of the Court as the hitherto full-time Medical Visitors were then invited to continue in a part-time capacity. This change had been planned for years, yet my Committee received less than three weeks' notice of it.

The sum offered to the Medical Visitor per visit was derisory in comparison with other part-time payment for central government work, including other work for the LCD. Despite our representations over four years it remains so.

Any Member of the British Medical Association who is interested in the work of a Medical Visitor is strongly advised to contact me at the address below.

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Chairman

Private Practice & Professional Fees Committee
British Medical Association House
Tavistock Square, London WC1

Overseas graduates and the MRCPsych

DEAR SIRS

The *Bulletin* has, in recent months, published papers on the performance of overseas graduates in the MRCPsych examinations,[1,2] and on their circumstances, career-wise, after they have been successful in the final examinations.[3] This expressed concern of the College for the welfare of overseas graduates is very commendable, and I hope will go a long way towards assuring them that the College has their interest very much at heart. The surveys were initiated by, or emanated from, the Collegiate Trainees Committee, the Chief Examiner, and the Overseas Trainees Sub-committee.

I actually did hope, on reading the papers by Dr White and Professor Cawley, to find the greater failure rate of overseas doctors explained. Alas, this was not to be. For, in his Summary, the Chief Examiner stated *'It is not possible to pinpoint specific causes of failure'* (my italics).

One would have thought that the pinpointing of the causes of the overseas doctors' higher failure rate was the essence of the whole exercise. I do appreciate that it is a very difficult thing to do, but feel that the Chief Examiner and the Chairman of the Collegiate Trainees' Committee should at least have attempted to answer the basic question. Surely, it is not *impossible* to figure out why people fail examinations?

People fail examinations because (a) they have insufficient *information* for the written work; (b) they are deficient in *clinical skills*; (c) they are unable to *sustain a discussion* at the orals; (d) though well informed, clinically competent and ordinarily able to discuss a wide range of subjects, they are overcome by anxiety and self-doubt on the big day; (e) they generally lack 'examination techniques', or (f) the examiners deliberately mark them down in the written work, harass them in the clinicals, or fire questions at them, at machine-gun rate, in the orals, to ensure their failure. This may be because the examiners disapprove of the candidates' race, religion, attire, country of origin, political inclinations or accent.

This study has now gone so far, that to retreat would be even harder than to proceed. Therefore, having started, let us finish. Would the Chief Examiner and the Chairman of the Collegiate Trainees' Committee consider repeating this exercise, to try to obtain data on the possible causes of failure listed above? Item (d) would be very difficult to quantify, but I think that most candidates would be willing to supply a self-rating of their emotional states during the examinations; item (f) would also require an honest contribution from the examiners, as to what their feelings were towards the candidates they examined. But if this further work can be done, it would ultimately give real meaning to this search, and identify the forms of assistance most appropriate to those in difficulty.

IKECHUKWU AZUONYE

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REFERENCES

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

[2] CAWLEY, R. H. (1986) Overseas graduates and the MRCPsych. *Bulletin of the Royal College of Psychiatrists*, **10**, 60–63.

[3] BHATE, S., SAGOVSKY, R. & COX, J. L. (1986) Career survey of overseas psychiatrists successful in the MRCPsych. *Bulletin of the Royal College of Psychiatrists*, **10**, 121–123.

DEAR SIRS

Dr Azuonye quotes me as saying that it is not possible to pinpoint specific causes of failure. In my paper I continued 'the MCQ's are not specifically to blame, nor are the essays; nor in the Membership Examination is the clinical'. This conclusion followed fairly detailed analysis of reasons for failure in the Autumn 1984 examinations. It is worth recalling that the MCQ papers are marked by a computer which knows nothing of sex, race, religion, or countries of origin; the essay papers are marked by two independent examiners, neither of whom knows more about the candidate than his/her number.

The first three of Dr Azuonye's proposed causes of failure pertain to educational matters rather than the examination. His fourth point is interesting but difficult to substantiate. Many candidates from all backgrounds experience anxiety and self-doubt before and during examinations. It has always been so, It is even claimed, on good authority, that people tend to give of their best in challenging tasks only if they experience at least a degree of anxiety. Dr Azuonye's hypothesis, which he would have us test, is that overseas candidates are more bedevilled by anxiety and self-doubt in the clinicals and orals than are indigenous candidates.

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'.