Psychiatry is the only field in medicine which is founded on both biological and behavioural sciences. It requires understanding of the biological basis of human behaviour, a grasp of new behavioural mechanisms and an understanding of psychopharmacology. A background of behavioural sciences is needed in order to understand the essentially human aspects of human adaptation and maladaptation and to comprehend psychodynamic theory.

Lack of clear boundaries of the scope of psychiatry in a developing country like India is not a serious drawback. As rightly pointed out by one of the former Presidents of the Indian Psychiatric Society, Dr Ajita Chakraborty, (1974), 'Developing countries are underdeveloped in relation to developed countries in matters of technology and its implementation, the Western expertise and know-how are being accepted with open arms by these countries. But the idea of underdevelopment should not be carried too far, especially in the social sciences. Medicine is perhaps a part of technology, but psychiatry is surely part of both technology and the social sciences. What panacea has been achieved in psychiatry in the West that needs to be imported? Take the two well developed facets: (a) Physical methods and drug treatment—these are being widely used all over the world without any difficulty, the techniques of application are not too complex; (b) Psychotherapy with all its ramifications—an immensely controversial area, the usefulness and universal applicability of which are doubted. The inherent limitations of time, expense and number of patients who can be treated make the usual methods of psychotherapy of restricted value. Above all, indigenous practices often serve the same purpose. The fact that these are not recognized as psychotherapy nor codified as such, does not make a great deal of difference.'

Today, India is in a better position in the field of medical technology and has the added advantage of its cultural heritage and social system, so necessary and valuable in the field of psychiatry. Recent trends in postgraduate education seem both healthy and hopeful.

References

Sharma, S. D. (1976) Psychiatry as a speciality. Paper read during the Symposium on Postgraduate Training of Psychiatry in India for the 28th Annual Conference of the Indian Psychiatric Society held at Nagpur in February 1976.

Chakraborty, Ajita (1974) A challenge of transcultural psychiatry. *Transcultural Psychiatric Research Review*, XI, 102-7.

CORRESPONDENCE

CRITERIA FOR SENIOR REGISTRAR APPOINTMENTS

Dear Sir,

In their statement in the June 1979 issue of the *Bulletin*, Professor Pond and Professor Rawnsley gave the criteria for a Senior Registrar's appointment in Psychiatry.

Although slightly belated, this directive would be helpful to both the candidate, who will know that there is no point in applying until he obtains the MRCPsych, and to the Appointment Committee as well as the Regional Health Authorities, who should mention clearly this minimum educational qualification when inviting applications. The statement recommends 'that the entry point for this grade should normally be the possession of the MRCPsych or an equivalent higher degree (this does not include the DPM)'.

I assume that this guideline will be applicable to all sub-specialties of psychiatry, to which the College has a duty to maintain the standard, and therefore this is equally applicable to the sub-specialty of mental handicap. Unfortunately, this sub-specialty still remains the Cinderella of the Health Service. Periodical scandalous outbursts occur, followed by Inquiries: some scapegoat is promptly found and then everything is forgotten for a time—where radical surgery is needed, only superficial cosmetic application is done. As a result, young psychiatrists generally become very unenthusiastic about entering the field of mental handicap, especially in view of the lack of scope for study, research and general financial gains.

Owing to the above, quite a large number of mental handicap hospitals are functioning with a third or half the number of Consultants they should have, which

obviously puts an enormous strain on those who are in post. For the last two years we have been trying to fill our two vacant Consultant posts; we have not had any applicants with MRCPsych, but one or two Senior Registrars with only the DPM applied and so were rejected by the Committee.

Now, if the recommendation is strictly adhered to (and I believe it will be), I see no hope of full recruitment for Consultant posts in mental handicap hospitals being achieved, and thus the upgrading of patients' care and treatment will be seriously jeopardized. Unless the College finds an alternative way of staffing mental handicap hospitals, there can be no improvement in the standard of care, therefore defeating the College's role.

The only alternative I can suggest is the practice of 'Comprehensive Psychiatry'. In this, the discriminating terms such as General Psychiatry, Mental Handicap, etc are abolished. A Consultant Psychiatrist who has adequate clinical knowledge and training should be able to treat any psychiatric patient, whether or not some element of intellectual deficit is involved. Also, it is not uncommon to find some chronic schizophrenic after years of treatment being branded 'subnormal' and sent to a long-stay ward of a large mental handicap hospital on a par with any general psychiatry hospital. If we abolish this discriminatory terminology, then the staff recruitment prospects will be better and a higher standard will be maintained. Otherwise I see no hope of an improvement in the mental handicap hospital, which will remain a sore point to the College.

UTPAL J. DEY
Consultant Psychiatrist

Brockhall Hospital,
Blackburn.

THE MRCPsych EXAMINATION

DEAR SIR,

We would like to respond to the points raised by Dr. Srinivasan in his letter, (*Bulletin,* July 1979, p 125).

The best criticism of the APIT Exam Workshop is not, as Dr. Srinivasan suggests, that it 'adds to the confusion', but that APIT has joined the bandwagon by helping candidates to pass an examination it has always opposed! In fact, the Workshop was designed to help those candidates who are known to be clinically competent but who repeatedly fail the exam because of faulty technique. We would refer to a letter in the APIT Newsletter (April, 1979) from a candidate who attributed her success at the third attempt partly to our Workshop where she learned (1) a logical system of formulation; (2) the need to leave adequate time within the hour to think and write it out; (3) that the examiners would not demand a single firm diagnosis; and (4) that she should not make it such hard work for the examiners to 'extract' information from her. This candidate also comments on her experience at different centres, and it is in response to all these factors that we wrote the letter requesting clarification and standardized practices.

Inevitably, the Workshop also attracts a proportion of candidates who are not clinically competent and who are 'confused'. The problem with the MRCPsych exam is that it simply fails such doctors and provides no impetus for improvement in their basic training. This has always been APIT's criticism. How can a trainee spend three years in an 'Approved' post, be considered ready to take the MRCPsych exam by his clinical tutor, and yet not know how to record the mental state examination?

Dr. Srinivasan quotes a pass rate of about 50% in the MRCPsych exam last year as evidence that one should not be pessimistic. If this is a reliable measure of the standard of clinical practice it does not suit his argument well, as the pass rate has *fallen* over the years, not risen[1]. He also fails to point out that for overseas trainees the pass rate is very much lower than this, which is probably a reflection of the fact that these doctors are much more likely than their UK counterparts to work in 'peripheral' hospitals where even Dr Srinivasan admits 'there is room for improvement' in the training provided.

Our recent survey of training in one Region supports this view as 37 out of 43 trainees at the undergraduate teaching hospitals had been specifically taught how to record a mental state examination, whereas only 23 out of 46 at regional hospitals had been so taught. The figures for the teaching of formulation are lower and similarly disparate, and those for the teaching of interview skills pathetic. It is not, therefore, surprising that trainees in these hospitals often regard the MRCPsych exam with enormous pessimism and desperation. They become totally preoccupied during their first year with the need to pass the Part I MCQ hurdle, and this detracts from the essential task of acquiring basic clinical skills. The importance of 'clarification of examination protocols' should not therefore be underestimated, and if, for example, a candidate knew he would be given 10 minutes specifically to write a formulation in the exam, he would presumably be more insistent that his consultant teach him exactly what this involves and allow him to practise this skill each week in his routine work. Any hospital which does not offer this facility should not be considered suitable for training, and the standard of clinical practice may indeed be questioned.