(CYP) IAPT, so I fail to see the relevance. In fact, this stark statistic is probably one of the reasons why CYP-IAPT places such a huge emphasis on participation – an element of CYP-IAPT that is completely disregarded in this article.

Admittedly, the implementation of outcome data collection has been problematic, but this is a huge development on a massive scale. This is not about monitoring data in one service, this is about setting up a national system for monitoring and comparing outcomes. Anyone can set up a spreadsheet for a few patients, but linking multiple electronic patient record systems into a central reporting mechanism is a bit more of an undertaking.

Catherine J. Swaile, Mental Health Commissioner, Haringey, UK, email: cathyswaile@hotmail.com

Note: The opinions expressed here are the author's own and not necessarily those of any clinical commissioning group, or Haringey Council.

1 Timimi S. Children and Young People's Improving Access to Psychological Therapies: inspiring innovation or more of the same? *BJPsych Bull* 2015; **39**: 57–60.

doi: 10.1192/pb.39.5.261a

Raising the standard: it's time to review the MRCPsych examinations

The MRCPsych examinations are the qualifying examinations for membership with the Royal College of Psychiatrists and are generally undertaken in the second and third year of core training. In combination with workplace-based assessments and the Annual Review of Competence Progression (ARCP) the exams are essential to progressing to advanced training and eventually a Certificate of Completion of Training (CCT). The exams currently involve three multiple choice (MCQ) format papers and a single clinical skills examination consisting of 16 varied stations (Clinical Assessment of Skills and Competencies, CASC).

No one doubts that to pass the exams necessitates a significant investment of time and energy, which detracts from trainees' experience on clinical placements, other educational opportunities, and their personal lives. Trainees' efforts should be rewarded with a process of learning and enrichment that develops their skills and knowledge, not simply another 'hoop to jump through' on their way through training. The MRCPsych courses offered by training hospitals go some way towards providing additional education, however, it is significant that trainees universally rely on practice questions rather than course attendance to pass exams. Some trainees will even pay for additional, privately run courses that focus solely on preparation for the exams. This suggests a fundamental disconnection between the exams and the learning objectives of training programmes that needs to be bridged.

The curriculum available to trainees is vague and fails to provide any real guidance towards training in the first 3 years. Content is frequently outdated and does not reflect the realities of clinical practice. The MCQ format is overly reliant on rote memorisation of lists of facts without regard to the context and complexities of clinical decision-making. The exam process neither encourages nor rewards trainees who take time to read broadly around the curriculum themes, instead relying on a narrow set of questions that are recycled year after year.

There is a lack of depth in the content tested, exemplified by the 'history' component which requires trainees simply to associate a list of important figures with a one-line description of their contribution. No attention is paid to the complex history of Western psychiatry or to important issues that are ongoing. Psychiatry more than any other field of medicine suffers from controversy regarding its role and relevance, and questions about aetiology, nosology, treatment and ethics. It is crucial for trainees to progress with an appreciation of these topics, yet the MRCPsych exams completely fail in this regard.

I suggest that a complete review of the MRCPsych curriculum and examination is overdue. The MCQ component should be reduced in favour of short-answer and/or clinical scenario formats. The curriculum should be updated to include more current research in basic sciences, as well as milestone papers in the history of psychiatric research. Historical, cultural and philosophical themes should be included in the curriculum and represented in assessments. Learning objectives for each theme should be specific, and accompanied by essential reading lists to guide trainees and exam questions.

In summary, if the goal of training is to produce highly skilled, well-rounded trainees, then the curriculum and examinations should reflect this. Instead, they assess a bare minimum level of competency, neglecting important developments and issues that are highly relevant to our daily practice. I believe that new psychiatrists deserve more than 'minimal' competence in return for their efforts, as does the profession, and most importantly, our patients.

Greg S. Shields, Specialist Registrar, Maudsley Hospital, London, email: gregory.shields@slam.nhs.uk

doi: 10.1192/pb.39.5.262

The Royal College of Psychiatrists' response: Examinations have been a feature of medical training for centuries both in undergraduate and postgraduate education. The primary purpose of such examinations has been to define a minimum standard that the public and fellow professionals have confidence in. In recent years there has been a drive for examinations to also inform the learning process and to be conducted in a format that is evidence based. The current MRCPsych examination was introduced in 2008 within parameters laid out by the Postgraduate Medical Education and Training Board (PMETB; Principles for Assessment Systems). The requirements of PMETB were for all Colleges to use assessment formats that were supported by evidence in the literature as being a reliable assessment method. As a consequence, all Colleges developed written paper examinations that were based on the multiple-choice question (MCQ) format and clinical examinations in an Objective Structured Clinical Examination (OSCE) format. These two formats are regarded as the most reliable. The written papers moved away from short-answer and essay questions as there are concerns about the reliability of these formats. The current MRCPsych written papers have extremely good reliability (Chronbach's α consistently greater than 0.9) and the Clinical Assessment of Skills and Competencies (CASC) also has good reliability (Chronbach's α 0.75–0.85).

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.

Dr Wendy Burn, Dean, and **Dr Peter Bowie**, Chief Examiner, Royal College of Psychiatrists, London, email: c/o pb@rcpsych.ac.uk

doi: 10.1192/pb.39.5.262a

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.

Vivek Datta, Chief Resident, Department of Psychiatry and Behavioral Sciences, University of Washington Medical Center, Seattle, USA, email: vdatta@mail.harvard.edu

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.

doi: 10.1192/pb.39.5.263

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,