Why Do Candidates Fail the MRCPsych Part II?

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Candidates from our Institution have not been uniformly successful in passing the MRCPsych Examination. It was therefore decided to offer some specific guidance to our trainees who were about to take Part II, in the form of a short 'revision' course incorporating mock clinical and viva examinations. A small working party was set up to organize this.

One of the difficulties raised in the attempt to organize such a course was uncertainty about the standard expected of candidates, especially in the clinical and viva. We were uncertain too about reasons for failure. As has been pointed out (*Bulletin*, October 1982, **6**, 174–6) different examiners can vary wildly when marking the same essay paper, and the standard of the preceding candidates in the clinical examination can affect an individual result. We were aware of the current debate on the organization and content of the examination. Meanwhile, how could the trainees be helped?

I decided to send an open-ended exploratory letter to consultants who had recently acted as examiners, asking them for guidance and generalizations. The relevant text of the letter was as follows:

> We are organizing a revision course for the MRCPsych Part II examination. It would be of great help to us if you could indicate where, in your experience, candidates need the most help. Are there any specific faults associated with the clinical examination which tend to recur? Are there problems mainly associated with lack of factual information, or lack of clinical experience?

I sent the letter out to 71 consultants on the then current list of examiners, nationwide. Of the 47 (66 per cent) who replied, two misunderstood the purpose of the letter and did not offer any constructive help. A breakdown of the information obtained from the remaining 45 examiners, many of whom sent valuable and lengthy replies, is shown in the Table.

An overwhelming 87 per cent mentioned inability to present a coherent formulation as their chief 'reason for failure'. Many specified that an inability to extract and present the most relevant facts led to overlong or disjointed presentations which created a very bad impression. Often examiners recommended specific training in presenting a formulation suggesting that this skill is not often required outside the examination setting. In this context, suggested schemes for a formulation, such as that presented by Dr Greenberg *et al* (*Bulletin*, September 1982, **6**, 160–2) are obviously a great help, but I would personally welcome specific guidelines from the College itself to remove further ambiguity and uncertainty from the examination.

The Table is largely self-explanatory. The examiners, following the direction of the letter I sent out, focused their replies mainly on the clinical examination. As a pass mark in the clinical is mandatory to pass the whole exam, this is obviously the most important area. Also the skills involved in taking the MCQ and the essay have already been tested in the Part I examination, though the factual knowledge required is slightly different.

The clinical examination is a test of experience and image as well as knowledge. Examiners used phrases such as 'clinical maturity', or 'good judgement' to describe what they were looking for in a candidate. They must be influenced by their own internal image of a psychiatrist when making a decision. An appearance of nervousness and uncertainty, often caused by the examination situation, does little to inspire the confidence of the examiner. Regular practice can help to overcome this. The tradition of formal presentations with critical evaluation by psychiatric elders has died out somewhat in day-to-day practice, as clinical rounds now tend to be more relaxed affairs. However, such formal presentations would be very beneficial in preparation for the clinical exam, so that the experience is no longer unnerving and the candidate can present him or herself as confident and assured.

Finally, it was a great relief to me that so few examiners pinpointed transcultural factors as reasons for failure. Of all possible faults, this was the one our course, or indeed any other, would be least able to remedy.

Table

Comments from examiners on MRCPsych Part II (n=45)	No. who identified this problem
Poor formulation	39 (87%)
Lack of factual knowledge in some area	18 (40%)
Lack of clinical experience	12 (26%)
Heedlessness of psychodynamic or social factors	10 (22%)
Heedlessness of management/prognosis	10 (22%)
Poor assessment of mental state	9 (19%)
Lack of experience in organic disorders	5 (11%)
Lack of experience in general medicine	3 (6%)
Self-presentation poor	3 (6%)
Transcultural or English language problems	3 (6%)
Poor written essays	2 (4%)
Too much weight to the esoteric	2 (4%)
Changing views to suit the examiner	1 (2%)
Stereotyped responses	1 (2%)

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