The Membership Examination—One Candidate's Viewpoint

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Several authors have written articles giving advice from the examiners' standpoint regarding the Membership examination in psychiatry but surprisingly little has been written by those with recent first-hand knowledge of the examination. Having failed the examination on my first attempt due to poor technique, I feel other candidates should be made aware of some possible pitfalls which they may encounter. Examinations, unfortunately, do not always necessarily examine that which they purport to examine. I also feel that some useful tips, which may make the examinee's task an easier one, should be passed on.

Candidates should be aware of the relative importance of the constituent parts of the examination. The clinical examination must be passed. A candidate can, however, narrowly fail one of the other three sections and still pass the examination if the overall mark he attains is over 50%. The approximate percentages of the marks attributed to each section of the examination are:

Clinical	40%
MCQ	30%
Oral	20%
Essay	10%

Practice is very important for each part of the examination. The candidate should practise viva examinations and present clinical cases to his peers and senior colleagues. He should be aware of time constraints, divide the time appropriately and ensure he does not run out of time.

The essay—an easy start?

It is rare for a candidate to fail the Membership examination overall by failing the essay paper only.[1] There has been a recent change in emphasis regarding the subject matter of the essays. There is now more emphasis on evaluation, e.g. of services, psychotherapy etc., and on specific problem management.

Many of the questions are multi-part questions so it is a useful exercise to underline the important words after reading the questions carefully. Take, for example, the question about hyperkinesis in the essay paper on May 1987: "Write an essay on the **characteristics, presumed origins** and **diagnostic criteria** of hyperkinesis in children. Give an account of modern approaches to **management** and treatment." The marking system for answering this question will be divided into four parts, marks being given for characteristics, presumed origins, diagnostic criteria and management. The candidate must ensure to discuss each of these aspects in relation to hyperkinesis.

The essay paper can be passed without any direct references to well-known publications but, if appropriate, they will most likely improve the candidate's marks. Many papers, especially those which are epidemiological in nature, can be quoted appropriately whatever the question; e.g. in answering questions about mental handicap one could almost invariably make a relevant reference to the papers of Wright[2] and/or Day[3]. It is prudent to be certain of one's references. Examiners would be unlikely to give extra marks to the candidate who referred to Wright as being of the male gender. A candidate could prepare his own references in other fields such as psychiatry of old age, child psychiatry and so on.

It is often said that examiners, when setting examination papers, are influenced by what they have recently read. In the November 1986 essay paper one question asked for a critique on the dexamethasone suppression test. There was a review article in the *British Journal of Psychiatry* in April the same year.[4] Another question concerned the social, personal and interpersonal adjustment of the long-stay mentally handicapped patient who was moving to the community. The previous March an article in the *Journal* discussed the socio-psychiatric aspects of the young severely mentally handicapped and the family[5]—a closely related topic. Similarly, in the editions of the *British Journal of Psychiatry* between September and December 1986, there were six articles which were very closely related to four of the questions on the essay paper of May 1987.

The MCQ—too much knowledge is a dangerous thing!

The multiple choice paper is the part of the examination which seems to be the least well received. However, it would appear to be here to stay so the prospective candidate must learn how to pass it. When practising with past papers a good idea is to use three different answer columns: one for answers of which the candidate is certain, one for near certainties and a third for educated guesses. This helps each individual to judge whether guessing will prove profitable or not. Similarly, a candidate can judge how successful guesses are in different subjects, e.g. psychopharmacology, psychotherapy etc.

The pass mark is not fixed but in recent years has hovered close to the 50% mark. Presuming one will get 10% of the questions wrong (a not unreasonable presumption as candidates will realise when practising), one has to answer at least 210 questions to get over 50%. One viewpoint is that since a candidate has some knowledge of psychiatry, an educated guess has a better than a one in two chance of being successful. The logical extrapolation from this is that the candidate should answer all 300 of the questions. However, this view does not have universal acceptance.

The wording of multiple choice questions is probably responsible for most controversy. It is difficult to be dogmatic regarding the wording but:

(a) "features of ... include" or "the following features occur in ..." makes no statement regarding frequency;
(b) "may occur", "often occurs" introduce frequency;
(c) "commonly" or "frequently" probably means in more than 50% of cases;
(d) "characteristic" should mean frequently occur are typical and of some diagnostic significance.

Finally, with regard to multiple choice papers, too much knowledge is a dangerous thing. The paper is set some time before the examination so recent publications will not have been considered when the answers were formulated. Also candidates should be aware that the examiners who set the paper may not have heard of the candidates' own most recent amazing discoveries.

The viva—the value of first principles

Many of the observations pertaining to the viva examination are equally relevant to the clinical examination. Generalisations are notoriously untrustworthy, but nevertheless I think it a useful maxim that candidates should, when in any doubt, go back to first principles. This demonstrates to the examiner that, rather than rushing in, the candidate is quite capable of considering the basics and applying them as appropriate.

In recent examinations, as in the essay paper, the emphasis in the viva examination has also changed considerably. Although examiners may still ask candidates about any topic relevant to psychiatry, they are now less likely to ask about papers recently read. The current approach is to discuss with the candidate between three and five case vignettes concerning management problems that a psychiatrist may encounter during his working day. The vignettes given are commonly rather sketchy and in answering it would seem advisable to initially return to first principles, e.g. "I would take a full history and do a mental state examination". One could hardly lose marks for this approach. While making his initial comments the candidate can be thinking about the more specific management of the problem presented.

The examiners want to make sure that the candidate is safe and orthodox. It is advisable to give the conventional answer before discussing any esoteric management plans.

The clinical—the multi-disciplinary approach

The ill-understood word 'formulation' has now passed into the annals of the Membership examination. In the interests of clarity, candidates are now asked for their assessment of the case, their suggested management plan and the likely prognosis for the patient.

When the candidate finds out to what examination centre he has been allocated, it may be worthwhile finding out what he can about the centre; e.g. certain hospitals are more likely to favour a diagnosis of alcoholism secondary to depression rather than depression secondary to alcoholism. Also, some hospitals are more likely to make a diagnosis of schizo-affective illness than others.

When taking the history from the patient, one should remember to ask the patient what treatment has been given since the illness began. More importantly, perhaps, the candidate should ask the patient if he knows what the diagnosis is. This is certainly legitimate and frequently fruitful, as patients become increasingly knowledgeable about their illness. Suicidal risk must always be assessed. When in doubt, play safe, i.e. a patient is suicidal until proven otherwise. If the examiners believe a patient to be suicidal and the candicate disagrees, it is likely that he will be failed because he is not considered safe. On the other hand, if the candidate says the patient is suicidal and the examiners disagree, the candidate may lose some marks for being excessively cautious or misinterpreting signs and symptoms, but he is unlikely to be failed for this error alone.

One must be prepared to present the full case, a summary in a paragraph or a one-sentence assessment. A diagnosis from ICD-9 should be used if possible. A diagnosis of personality disorder is difficult to defend and probably best avoided. If the diagnosis is schizophrenia, the candidate must be able to state what criteria were used for diagnosis: Feighner's, Spitzer's or Schneider's. Many topics recur in every examination, particularly in the discussion of differential diagnosis. One should have views on schizo-affective psychosis as a distinct diagnosis (the easier position to defend is to say it is a form of schizophrenia as classified in ICD-9), the reactive/endogenous dichotomy and whether anxiety and depression are on a continuum. There is evidence for and against each viewpoint and once the candidate can make a defence of the position he takes he cannot be faulted.

Psychiatry is now a multi-disciplinarian specialty. Therefore, when the candidate is discussing further assessment of the patient, one must include a corroborative history from the social worker, observations regarding behaviour and concentration by nursing colleagues and those in occupational therapy, and assessment of intelligence and any special deficits by psychology colleagues if appropriate.

When discussing aetiology remember the three Ps: predispose, precipitate, perpetuate. Aetiological factors can and should also be divided into somatic, psychological and and socio-environmental factors. Physical treatments play only a minor part in the management of the patient. Again the multi-disciplinarian approach should be used and the skills of the other team members should be incorporated whenever appropriate. Both management and prognosis ought to be divided into short-term and long-term.

Comment

The Membership examination may be viewed as a legitimate test of one's psychiatric knowledge or, alternatively, as a hurdle which must be overcome before one progresses further in one's psychiatric career. It is hoped that this essay may help some of the candidates who might otherwise fail, not because of lack of knowledge, but because of poor examination technique.

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