dynamic logic.

One cannot be both insular, exclusive *and* cost-effective. The implication that the ordinary day-to-day patient-care does not deserve the direct and exclusive interest of the psychotherapist is unacceptable. Only to the extent that psychotherapists are an integral part of down-to-earth patient-care will they be able to prove their services are economical.

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Restructuring the MRCPsych

DEAR SIRS

Having read Dr G. E. Berrios' account of Professor Cawley's working party report on the MRCPsych Examination, I would like to argue against the suggestion that the Basic Sciences be examined as a minor part of the Final Examination. Indeed, after the first paragraph on the Preliminary Test, they were not mentioned again in the entire article.

Whilst the Examination, as it exists at the moment, is far from ideal and can be subject to valid criticism, it would be a pity if its merits, and the beneficial influences it has had on psychiatric training, were not appreciated. The Preliminary Test has been criticized because of an undue emphasis on basic science, at a time when candidates most need to be assessed on their clinical skills and are keenest to start developing them especially in the field of communicating with patients. In part, the Preliminary Test was set up to select candidates who had a reasonable chance of completing the subsequent clinical test in which this communicating skill is important. The published figures show that it has been as successful in meeting this objective as any comparable examination. Equally, and probably correctly, the test was put in to make sure that at some stage in their careers, the candidates should study those Basic Sciences which are relevant to the practice of psychiatry.

In a multidisciplinary clinical team, one of the psychiatrist's functions is to integrate his knowledge of brain function, psychopharmacology, endocrinology and mental mechanisms in health and disease with his own and other members' observations on the patient's behaviour and communications; it is indeed his unique contribution to be able to do this. Other fully trained members of the team should all be skilled at communicating, and should equally not be occupying senior positions in their own professions if they are not. It is only in comparison to other medical disciplines that this communicating ability distinguishes the psychiatrist from others.

A view of the Preliminary Test is that one of its most important aims should be the early identification of individuals who, for any reason, are unlikely to develop the necessary clinical skills. If this is so, then the Preliminary Test could consist solely of a basic examination of clinical competence, emphasizing this feature. This would obviously make the best filter for those unsuited for further psychiatric studies, but there are good reasons for rejecting this extreme option. If the Preliminary Test Basic Science Examination was moved in with the Final Clinical Examination, it is highly probable that the latter would overshadow it. In my view, more consultants have difficulty in understanding and evaluating the current advances in the appropriate basic sciences and their application to the new physical treatments than in maintaining their basic clinical skills. The Preliminary Test, as at present constituted, is making a valuable contribution by starting to produce a generation of psychiatrists who, with their other training, will be adequately prepared in both these aspects of the psychiatric discipline, and who will be in a good position to cope with and adjust to advances in both types of knowledge.

It is in the testing of knowledge of the biological, pharmacological, psychological statistical, and other aspects of psychiatry that the multiple choice question paper comes into its own. Again, to cope with the advances in current knowledge, there remains the need for a separate and distinct basic science examination, following a course of study spread over approximately a year. Material which is inadequately examined is unfortunately studied in any depth only by those able and energetic candidates for whom examinations are superfluous. Professor Cawley suggested that 'special emphasis' would be put on assessment of clinical skills and case formulation, and that the second examination would be a 'second clinical examination'. However, an examination so heavily biased towards clinical skills would gradually reduce candidates' commitment to a period of study of the basic sciences during their training.

I agree it is time for the College to look at its examination and probably to revise it. I am suggesting that the retention of a significant place for the basic sciences is of special importance at this stage in the development of psychiatry and that this should be an important part of the debate on the improved means of selection, teaching and assessing our future colleagues. The tradition of the psychiatrist spanning the area between the applied sciences and psychotherapy should especially be continued at this time, whilst the whole area of relevant information is developing so rapidly.

ALEXANDER M. P. KELLAM

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DEAR SIRS

I do not want, at this stage, to take issue with Dr Kellam's views: I hope they will provoke correspondence on these important matters. But I should be grateful for the opportunity to correct what appears to be a misunderstanding in his reading of Dr Berrios' account of my statement to the Education Committee. I should like to make two points.

First, I did not say, and would not wish to imply, that the basic sciences will be examined as a *minor* part of the Membership Examination. Second, it is the Membership Oral Examination—always concerned with clinical topics—which would be replaced by the 'second clinical'.

R. H. CAWLEY
Chairman of the Working Party for the Review of the MRCPsych

Sudden deaths in hospital

DEAR SIRS

I would like to comment on the article by Dr Crammer entitled 'In-patients sometimes kill themselves' (*Bulletin*, January 1983, **7**, 2–4). This is obviously an important topic and needs to be brought from its usual dim position more into the light. However, although there was interest in his account of discussion meetings with all manner of staff from management teams to porters in order to better elucidate procedure and offer support to the staff, patients seem to be totally left out.

In my experience fellow patients very often know about the mental anguish of the dead person prior to the suicide, and have much knowledge too of what he may have done on the day of the act itself. The in-patient group also responds to a death in its midst in many ways from guilt to depression to dissociation. I would suggest that it can be of great therapeutic value and benefit to the other patients who have to live and mourn with a death in their midst if there can be an emergency ward meeting for staff *and patients*. Patients implicity expect safety and to be cared for by mental health professionals, however depressed and suicidal they are feeling. The great anxiety engendered by the fragmentation of this safety can be dealt with and a valuable opportunity to discuss with the patient group about endings and beginnings can follow on when a death can be tentatively approached by those who survive, including the staff.

Dr S. Gladwell and I did some unpublished research a few years ago into examining the deaths of patients in a large mental hospital from 1958 to 1974. Of the fifteen deaths by suicide we discovered, four of these had not had a physical examination recorded in the notes. I am not writing this to criticize hospitals or doctors, and it is possible that they were examined and it was not recorded. However, it may be that patients who were in very regressed states of mind somehow were not able to be 'put into doctors' hands' in the literal sense and have the experience of being held by the doctor. I think that this induction into the hospital of the suicidal and regressed patient is of the utmost importance, as are the more well-known areas of such patients being bathed and fed.

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Historical ephemera

DEAR SIRS

I have found on approval visits for the College that there is a great wealth of historical interest in the older psychiatric hospitals. I am sure there is a need for someone to co-ordinate not only the local history of these hospitals, but also old and new photographs. Most hospitals have their own photographs of certain buildings in their library and also a modest history of their psychiatric hospital. Is it possible for the College library to be responsible for such ephemera? I would also like to propose that each psychiatric hospital is contacted to give details of what is available and also what is needed to make its past and present history complete for posterity.

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Planning registrar and senior registrar training in mental handicap

DEAR SIRS

I wish to refer to Dr H. G. Kinnell's reply to my letter (*Bulletin*, September 1982, **6**, 163) and to state that the views expressed in no way reflected training facilities in Botleys Park Hospital.

If I could refer to my original letter again, it took a general view in the country as a whole without reference to any particular institution.

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ECT in America

DEAR SIRS

Despite the disclaimer on the front of the *Bulletin*, it is possible that some of its contents might find their way into the press as evidence of authoritative opinion. There are so many attacks upon electric shock treatment these days that this valuable treatment is sometimes in jeopardy on both sides of the Atlantic.

I therefore hasten to write to you concerning Dr Bick's amusing and interesting commentary upon psychiatric training in America (*Bulletin*, January 1983, **7**, 11–12).

The indications for electric shock treatment are internationally recognized by well-trained psychiatrists and are the same on both sides of the Atlantic.

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