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The award of Membership without examination

Professor Khan raised the issue of award of Membership of the College without examination terming it as 'through the back door' (*Psychiatric Bulletin*, January 2006, **30**, 3–5). Although he has raised some pertinent issues and some of his objections appear to be valid it was not fair to generalise and include everybody in the same category. The award of Membership without examination broadly falls into two categories. One is to psychiatrists of international eminence and the other is to international fellows recruited under the International Fellowship Programme (IFP).

Most international fellows from Pakistan possess the fellowship (FCPS), which according to Professor Khan's own description, 'is difficult and requires consistent hard work, application and discipline'. FCPS is an exit exam and candidates do not require further training to become eligible for senior positions in psychiatry. Psychiatrists who have been appointed to consultant posts via the IFP have had a series of interviews, including a formal interview by a panel which has included a College representative.

We strongly disagree with Professor Khan's opinion that it was a back door entry to Membership for these psychiatrists. The Dean's response to the article was apologetic. It was disappointing that rather than addressing the main issue of award of Membership to those of 'international eminence', he dwelt on international fellows. The College has already suspended the processing of applications of international recruits, who can no longer become members despite having equivalent qualifications, being on the General Medical Council specialist register, having the certificate of completion of specialist training (CCST), Specialist Training Authority approval, experience of training senior house officers in psychiatry for the Membership exam, registering for continuing professional development and above all despite being promised Membership by the College authorities.

We were surprised by the statement from the Dean that international fellows were 'seduced by the promise of MRCPsych by people who have had no power to make such promises' (*Psychiatric Bulletin*, January 2006, **30**, 6). If the President, Deputy Dean and the Head of Education of the College had no authority, then why did they seduce the international fellows at the crucial stage of recruitment? Membership was viewed as a major incentive by many of the candidates. They now feel cheated and betrayed by the College.

Declaration of interest

Both authors came to the UK under the International Fellowship Programme from Pakistan. They take pride in developing a close association with the College. One author was conferred the Membership under Section III 2(ii) of the Bye-Laws in 2004 but the other was recently refused Membership as a result of legal advice relating to Section III 2(ii).

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I read with interest the debate about the International Fellowship Programme and the award of Membership without examination. As a psychiatrist returning to my home country I would like to share some views on these issues.

There is a shortage of psychiatrists in countries such as Pakistan and Sri Lanka but a large number of doctors trained in these countries work as psychiatrists in high-income countries. However, this situation existed long before the International Fellowship Programme came into being. As long as there is a shortage of psychiatrists in high-income countries and free movement of doctors for employment is permitted, this 'exodus' will continue.

The postgraduate training programme in Sri Lanka is unique in that it requires 1 year of compulsory senior registrar training overseas, prior to obtaining certification as a consultant. Of the trainees who passed the MD Psychiatry examination and proceeded overseas, only about a quarter have returned to Sri Lanka. Thus the larger loss in Sri Lanka is of trainees and not consultants.

Many accusations have been levelled at the Fellowship Programme for offering attractive packages to lure experienced psychiatrists to the UK. It could also be viewed as providing opportunities for those who choose to work under difficult circumstances in low- and middle-income countries to experience working in a different system and reap financial benefits.

The recognition of equivalent qualifications and the granting of membership of professional organisations occurs in many professions. This has enabled skilled professionals to work in different countries without having to repeat their basic training. The Royal College of Psychiatrists has been quite conservative in the recognition of equivalent qualifications compared with some of the other Colleges. For example, overseas graduates who hold a postgraduate diploma which is recognised by the Royal College of Physicians and which requires a comparable period of training may be permitted to enter the MRCP(UK) part 2 written examination with exemption from the MRCP(UK) part 1 examination and without the need for further training (http://www.mrcpuk.org). The Royal Australian and New Zealand College of Psychiatrists also grants exemption to psychiatrists who have qualified overseas, dependent on their training and experience (http://www.ranzcp.org).

Those who obtain the MRCPsych by examination do undergo good training and work very hard to obtain the qualification. However, this does not mean that training programmes in other countries are necessarily inferior in quality.

If the College decides to continue to award MRCPsych without examination, it needs to develop clear criteria on how applications are reviewed and publish these criteria so that applicants are clear about the expected standards. The equivalence guidelines of the Royal Australian and New Zealand College of Psychiatrists are ones that the College would do well to emulate (Royal Australian and New Zealand College of Psychiatrists, 2004).

Declaration of interest

V.d.S. worked as a consultant psychiatrist in the UK under the Fellowship Programme. She applied for MRCPsych under Bye-Law Section III 2(ii) in 2005.


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ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS (2004) *The Royal Australian and New Zealand College of Psychiatrists Equivalence Guidelines*. http://www.ranzcp.org/pdffiles/training/exempt/Equivalence%20Table%20Revised%20June%202004.pdf

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Professor Khan echoes a sentiment shared by hundreds of psychiatrists who have passed the MRCPsych exams after a great deal of hard work; it is frustrating to see others who have never been through the process still get the MRCPsych. Dr Bhugra states that this 'College is the only Royal College which has tried to be inclusive'. By doing what – handing out Membership for free! This is certainly *not* something to be proud of. This is a mere gimmick to entice psychiatrists to work in the UK and in my view greatly lowers the credibility of the College.

I moved from the UK to work in the USA and it is very common to see psychiatrists who trained in the UK and have moved here. Psychiatrists still continue to come here from the UK, many even after passing the MRCPsych. One of the most common reasons cited is the inherent unfairness of a system where everything is based on need rather than on merit. In contrast becoming a Board-certified psychiatrist in the USA involves passing the exams of the American Board of Psychiatry and Neurology after the required number of years of training. There are no exceptions based on fame, repute or need.

MRCPsych is an award I was proud to add after my name and despite moving to the USA, I have continued to pay my fees to the College. However, I no longer see any point in paying over £300 a year for something that anyone can have and have decided to stop paying my annual Membership fees. However, since my fees are currently up to date, I continue to add MRCPsych after my name for the time being!

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In his excellent article Professor Khan raises concerns regarding the awarding of Membership of the College without adequate checks. He points towards the College's high standing and its ability to guide opinion in countries which have not yet developed such structures for themselves. The British Medical Royal Colleges have traditionally had this role throughout those Commonwealth countries that have largely adopted a UK-style postgraduate education system and teach in English. This is an enormous responsibility and at the same time reason for the College's dilemma. The College is not merely the guardian of professional standards and education but also provides professional guidance beyond its own borders. This is further complicated by the fact that to get a job as a specialist a psychiatrist does not necessarily have to be a member of the College, so the College has no effective role in controlling access to work as a specialist. This latter point is in stark contrast to Royal Colleges or similar bodies across the European Union whose primary role it is to control access to specialist jobs. It is this complex role with no effective control function regarding access to jobs that causes the dilemma faced by our College and exacerbates the problems described by Professor Khan. The answer could be to subdivide the three roles of: (a) controlling access to specialist jobs; (b) controlling education; and (c) setting standards and giving professional guidance at home and abroad.

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I fully agree with the views expressed by Dr Khan and I appreciate the comments made by Professor Bhugra (*Psychiatric Bulletin*, January 2006, **30**, 3–6). It is heartening to note that the College is striving hard to maintain the highest standards of training and ethics and that certain steps are being taken to establish new guidelines and criteria to uphold these standards across the board. MRCPsych is undoubtedly the most prestigious qualification and therefore it should not be awarded to those who fail to meet its standards.

Professor Bhugra mentions two groups of people who could be awarded this qualification without examination. However, there is another group which he fails to mention. Under Article 14, the Postgraduate Medical and Education Training Board (PMETB) can now consider the applications of many middle grade doctors for specialist registration who do not have the accredited higher specialist training or who have previously been unsuccessful in the MRCPsych examination. If some of these applicants are successful, then they will move on to the specialist register of the General Medical Council, thereby automatically qualifying for Membership of the College.

I suggest that the College sets up a tier system whereby these potential awardees, before being granted Membership, either take some form of modular examination or undergo a series of training workshops and courses. By implementing such a system the College will be able to appraise the knowledge and skills of these doctors objectively. It will also enable these doctors to match the standards achieved by those who acquire MRCPsych through normal means. If this is not possible then the College should seriously consider amending the Bye-Laws once again.

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I am writing to express the view of the Collegiate Trainees' Committee (CTC) on the issue of Membership without examination as discussed at the last CTC meeting. Although acknowledging the importance of recognising senior psychiatrists of international repute, trainees are opposed to the idea of indiscriminate awarding of the MRCPsych to overseas psychiatrists if they have not passed the UK examinations.

There are two lines of reasoning supporting this argument. First, there seems to be a plethora of ways in many countries to obtain a postgraduate psychiatric qualification, one of the eligibility criteria for the awared of Membership without examination (*Psychiatric Bulletin*, January 2006, **30**, 3–6). As some of these qualifications are not underpinned by training, assessment and quality-assurance systems as robust as those in the UK, awarding the reputable MRCPsych to holders of only these qualifications would seriously devalue the MRCPsych in the eyes of not only the medical community but also the public at large. Second, awarding the MRCPsych to those who have not toiled through a very rigorous UK training and assessment system would seriously discriminate against past, present and future generations of postgraduate UK trainees who have done so.

If the College feels the need to recognise psychiatrists who have not passed both parts of the Membership exam, it should ensure that there is some way to differentiate their title from that of those who have undergone the rigorous UK training.

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Response of College

The College has closed the category of Membership without examination on legal advice. The College wishes to make it possible for psychiatrists practising at consultant level in the UK or Ireland to become associated with the College at the earliest possible stage wherever they trained, qualified or gained experience. A consultation exercise is currently underway seeking the views of members

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and other psychiatrists on how this can best be achieved. The consultation form, which has been circulated widely, can also be downloaded from the College website http://www.rcpsych.ac.uk/membership/ConsultAsso_06.pdf

Choosing a career in child and adolescent psychiatry

Lamb *et al* (*Psychiatric Bulletin*, February 2006, **30**, 61–64) have reported the views and experiences of trainees in child psychiatry placements and their influence on the choice of child and adolescent psychiatry as a career.

The College recommends that 'trainees should have considerable experience in child and adolescent psychiatry at senior house officer level'. However, it seems that by the time trainees start a child psychiatry placement most have already decided on their career plan.

Senior house officers are accustomed to working within in-patient adult psychiatry units. The transition to a child and adolescent psychiatry placement can be disconcerting. Trainees have to work within a multidisciplinary team where their role and objectives are unfamiliar and seem remote from adult services. Trainees also find that their skills and work experience are not centre stage.

The College specifies that probably the most important ingredient of clinical training is regular direct supervision either individually or in a small group by the consultant (and where available) by specialist registrars. Regular direct supervision would also be valuable to help trainees reflect on their career goals.

We believe that providing a mentor (a senior colleague, specialist registrar) at the beginning of the placement, early involvement in novel training experiences (e.g. family therapy) and in-house workshops and seminars (e.g. child protection issues) could help create a rewarding training experience that could encourage trainees to perceive child psychiatry as a future career.

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Disseminating psychological skills in old age psychiatry services

It was encouraging to read about the level of interest in psychological therapies for older people in Wales (*Psychiatric Bulletin*, January 2006, **30**, 10–11). Older people will become more aware of psychological therapies and will request them more in the future.

The multidisciplinary team training in cognitive–behavioural therapy (CBT) which was devised and developed by Chris Williams is aimed at training a community mental health team in basic CBT skills, without the jargon associated traditionally with CBT. Hence, it is easily accessible to team members who have no formal training in the discipline. The system is designed to be used in part or whole by practitioners and can therefore provide a range of sessions for varied needs. Training material can be downloaded from http://www.calipso.co.uk

Having trained in Glasgow, I am now imparting these skills to my colleagues from the multidisciplinary team in north Dublin and they have been well received. It is difficult for any service to gain protected time for training. Whitfield *et al* (*Psychiatric Bulletin*, February 2006, **30**, 58–60) highlight the need for supervision, the development and maintenance of CBT skills as well as for the training and supervision of others. I suggest that the challenge in disseminating these skills is to locate and establish local centres of expertise which would provide supervision and ongoing training. This might prove particularly difficult in areas where no such therapies have previously been available.

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Evans and Reynolds highlight the limited access to psychological therapies for older people in Wales. Similar problems exist in England despite a commitment to psychological therapies in the National Service Framework for Older People (Department of Health, 2001) and the National Institute for Clinical Excellence guidelines for anxiety and depression (NICE, 2004).

A survey across Suffolk, Norfolk and Cambridgeshire for the National Institute for Mental Health in England (East Region) in 2004 showed that in several areas the availability of psychologists was very limited (survey available from NIMHE East Region or by e-mail from dm214@aol.com). College guidelines suggest there should be 0.5 psychologists per 10 000 population aged over 65 years, but few areas achieve this level and some have none. Interviews with community team leaders revealed that several had unfilled psychology posts owing to recruitment difficulties. Psychologists frequently support memory clinics, but the availability of drugs enhancing cognition has also increased the need for psychologists in the community.

Psychology resources are key for the supervision of other staff providing psychological therapies, behavioural therapy and psychometry where a diagnosis of dementia is in doubt. Unfortunately our survey revealed insufficient A grade psychologists to supervise assistants, and therefore the old age specialty was not attracting new entrants. Community psychiatric nurses (CPNs) are often trained in psychological therapies, but with a threefold variation in CPN numbers (from 2000 to 7000 population aged over 65 years per CPN), time for delivering these therapies was often limited. If we are to provide psychological therapies to older people with mental illness, the shortage of psychology resources needs to be addressed.

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NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE (2004) *NICE Guidelines to Improve the Treatment and Care of People with Depression and Anxiety*. London: NICE.

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Psychiatric comorbidity in foetal alcohol syndrome

With increasing media interest and public awareness and reports from North America regarding the prevalence of psychiatric comorbidity in foetal alcohol syndrome (FAS; Famy *et al*, 1998), concerns are being raised locally as to the knowledge of mental healthcare professionals of this issue. Clinical work with this group suggested that the wider mental health community has limited knowledge of FAS as a condition, despite international figures suggesting a prevalence rate of 1% in the community (O'Leary, 2004). Hence one of us (R.A.S.M.) devised a brief questionnaire to determine mental health practitioners' knowledge of the condition. The questionnaire was used at three local academic programmes attended by a mix of mental healthcare professionals.

Everyone (n=33) had heard of FAS as a condition but only five professionals felt able to recognise it. One person (a psychologist) considered FAS in the differential diagnosis and nine knew where to refer a person with FAS if the diagnosis was suspected or found. Only one individual with foetal alcohol spectrum disorder (FASD) was known to those professionals attending the programmes.

These results are similar to those from other studies (Nanson *et al*, 1995) and highlight the need for education in this area in order to guide UK practitioners in the recognition of the condition and what can be done to help affected individuals and their families. We believe there is an

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urgent need for resources to undertake this task.

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Flexible training

I am a senior house officer who has been training under a flexible training scheme for the past 2 years. Like any other trainee in psychiatry, I have read with great interest the recent publications regarding the imminent changes in training and I have wondered how flexible training will be affected by the introduction of modular and work place-based assessments.

I understand the College is committed to improving and developing flexible training (Ramsay, 2005) and am pleased to report that such has been my experience. During my 2 years as a flexible trainee I have experienced some difficulties in attending all teaching sessions because some in-house sessions fell on days that I did not work. Most flexible trainees work six sessions (equivalent to 3 days) a week.

It would appear that flexible trainees are satisfied with current training schemes. Flexibly trained psychiatrists have been found to outperform their full-time colleagues in terms of how quickly they gain College Membership (assessed by the number of examination attempts) (Mears *et al*, 2004). I am again pleased to report that this has been my experience.

It has been suggested that nationally 14% of all psychiatrists train flexibly (Mears *et al*, 2004). In 2003 over 60% of all applicants to medical schools in the UK were female (British Medical Association, 2004). It seems reasonable to predict an increase in the number of women trainees in psychiatry (Ramsay, 2005). This could mean more trainees wanting to train flexibly.

I think it is very important that the College considers flexible training during the current revision so that the scheme will be compatible with part-time working.

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RAMSAY, R. (2005) Women in Psychiatry: ten years of a special interest group. *Advances in Psychiatric Treatment*, **11**, 383–384.

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the college

Good Psychiatric Practice: Confidentiality and Information Sharing

Council Report CR133, March 2006, Royal College of Psychiatrists, £10.00, 48 pp

The central purpose of this report is to provide members with guidance on good practice in patient information privacy. This includes guidance on information sharing and on decisions about disclosure. It provides an in-depth development of the outline guidance given in *Good Psychiatric Practice* (CR125; Royal College of Psychiatrists, 2004).

In the interval since the first issue of these guidelines in 2000 there have been a number of changes in health service organisation, clinical practice and public expectations, as well as a general trend to augment the duty to disclose and to reduce professional privilege. Particular consideration has been given to the special issues surrounding the sensitivity of mental health information, the impact of changes in health service organisation, developments within practice (e.g. multi-disciplinary and multi-agency working) and the impact of new technologies (e.g. electronic communication and computerised information systems).

The focus is on practical guidance relevant to a variety of situations and issues throughout the National Health Service and independent sector that confront psychiatrists and other members of multi-disciplinary teams. Confidentiality is both an ethical and a legal issue and the approach adopted has been detailed in consideration of the ethical principles and legal framework that inform good practice.

The following topics are covered:

- Keeping patients and carers informed, including information sharing to provide healthcare.
- Information sharing between users and carers.
- Multidisciplinary teams and inter-agency working.
- Disclosure, including where there is a legal requirement to disclose, and where decisions are matters of professional judgement.
- Requests for case notes, providing reports.
- Media requests and video recording.
- Secondary uses of patient information, including research.

Services for Younger People with Alzheimer's Disease and Other Dementias

Council Report CR135, March 2006, Royal College of Psychiatrists and Alzheimer's Society, £10.00, 32 pp

Younger people with dementia and their carers frequently fall through the net of the health and social care services. During the 1990s an increasing number of these patients were referred to old age psychiatry services. In response to this new pattern, in 2000 the Royal College of Psychiatrists' Faculty of Old Age Psychiatry, in conjunction with the Alzheimer's Society, published a policy paper outlining the configuration of services for younger patients with dementia. The document was well received. In 2002 a review showed that a

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