

## EXAM PREPARATION

### Preparing For The MRCPsych Examinations

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#### Introduction

The MRCPsych acts as an exit examination at the end of the SHO grade, allowing progression to higher specialist training (1). The main object of training leading to the exam is to provide a generic grounding in psychiatry, covering: theoretical teaching, clinical competence and knowledge of research methods and appraisal (2).

The Authors are all members of the Royal College of Psychiatrists and Specialist Registrars in the Defence Medical Services. This paper is primarily based on our experiences of preparing for Parts I and II of this examination. It will provide general information regarding regulations, as well as advice on preparation and what to expect. Clearly we cannot hope to cover everything (the regulations alone are extensive), so an important part of this review is detailing where to find additional information.

#### Examination Administration

The Royal College of Psychiatrists (3) runs the examinations, and all initial enquiries should be addressed to the examinations office for Part I initially. The College also has a very useful website [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk), where information can be found about examination entry requirements and the timings of examinations as well as the examination curriculum. Requests for application forms must be made in writing to the examinations officer; these can be faxed but not emailed. The exam results are also published on the College website (3).

#### Eligibility

MRCPsych Part I applicants must have completed 12 months of full-time (or equivalent part-time) approved psychiatric training, either 12 months General Adult Psychiatry, or 6 months General Adult Psychiatry and 6 months Old Age Psychiatry. Candidates must also satisfy the requirements in terms of registration and be sponsored to sit the examination by both their clinical tutor and a consultant for whom they have worked for at least 4 months in the previous year.

Part II applicants must have had a minimum of 30 months of full-time (or equivalent part-time) approved psychiatric training; this includes the approved training for Part I. Twelve months General Adult Psychiatry is mandatory, with 18 months in sub-specialities, but no more than 12 months

maximum for any individual sub-speciality and up to six months in other specialities such as General Practice can be included. Training must be supported by evidence of attendance at an appropriate academic "MRCPsych" course (this is confirmed by the clinical tutor).

It is mandatory to have completed 6 months in either Child and Adolescent Psychiatry or Psychiatry of Learning Disability before one is eligible to join the college, regardless of whether the examination has been passed. It is important to check the website or write directly to the examinations department for the complete regulations and curriculum, especially if there are any doubts regarding eligibility or appropriateness of training. When making specific enquiries it is advisable to allow plenty of time, as the College can be slow to reply; exam time is a busy time. A maximum of 5 attempts at each part is allowed.

#### Inceptorship

The College wants future Members to be involved in its activities and Inceptorship offers such an opportunity (4). Benefits include receiving the *British Journal of Psychiatry* and the *Psychiatric Bulletin*, the *Inceptors Handbook* (this contains many of the regulations and details regarding the exams) and details of meetings and eligibility for election to the Collegiate Trainees' Committee. There is an annual fee. The Postgraduate Education Officer at the College will provide an application form. In addition to publishing the *British Journal of Psychiatry*, *The Psychiatric Bulletin* and *Advances in Psychiatric Treatment*, the College publishes the Seminar Series, under the Gaskell label (5).

#### Exam timing and venues

The Part I examination is held in March and September at each of the following locations: - London, Birmingham, Edinburgh, Dublin, Hong Kong and Cairo. The Part II examination is held in April and October at all of these sites, except Cairo. There is a significant date by which applications must be submitted, usually in the region of 4 months before the examination. Prompt application and good administration is required, since late submissions will not be considered until the next examination. The use of recorded or registered mail is recommended. There is an additional £50

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late applicant's fee. No refund of fees is given following withdrawal for non-certifiable reasons, so it is essential that each application is a serious one.

### **Format of the Part I examination**

Both parts of the examination have written and clinical portions and in both the clinical component must be passed in order to pass the exam. The examination fees cover both components, and in both Parts I and II, candidates who are unsuccessful on the written paper, will not be invited to attend the clinical and will have a proportion of their fees returned.

Part I MCQs now take the form of 200 individual statements, rather than the traditional stem questions, over 90 minutes. In 2003 Extending Matching Items will be introduced probably in both Parts of the examination (6). The results of the MCQs are released the following week. Successful candidates will be invited to the clinical examination, the location and timing of which (usually 1 month after the written paper) will be sent out by post. The clinical examinations can be anywhere in the UK and Ireland.

The Part I clinical involves interviewing a patient for 50 minutes (including basic physical examination), the patient then leaves the room, following which there is 10 minutes preparation time, prior to meeting the examiners. The examination focuses on history taking, mental state examination, aetiology and differential diagnosis. The Part I examination does not address treatment. Each candidate spends approximately 30 minutes with the examiners, generally divided into ten minutes presenting the history and mental state examination, then interviewing the patient in front of the examiners to demonstrate something outlined by the examiners. The final ten minutes or so are spent discussing the differential diagnosis.

The current clinical examination will be replaced in 2003 by a 12 station structured skills assessment, which will examine a candidate's ability to perform clinical skills in front of examiners. Further details on the proposed changes are available on the college website. (3)

### **Format of the Part II examination**

Part II has effectively a whole day of written examinations, starting with the Essay paper, a single essay in 90 mins from a choice of 5 topics including sub-specialities, a critical review paper, and finally three hours of MCQs, including a Basic Sciences paper and the Clinical Topics examination.

The clinical has two elements, the clinical interview and the patient management problems (PMP's). The clinical interview is

similar to Part I, but with a potentially more complex case, together with a greater focus on risk assessment, management and prognosis. There are plans to implement changes in 2003: these include increasing the time with the examiners to 40 minutes, and less emphasis on history presentation whilst increasing the emphasis on diagnosis, aetiology, management and formulation.

The Patient Management Problems (PMP's) are 30 minute periods spent with two different examiners discussing patient management problems, which are usually 4-6 clinical conundrums. In 2003 these will become standardised with the introduction of the Structured Oral Examination.

### **Revision Planning**

As stated above, the college requires early submission of applications allowing at least 3 months for revision. Considerable sacrifices need to be made when preparing for the examinations, both socially and personally. Applicants need high levels of commitment. It is essential to plan one's revision carefully, giving specific thought to major life events both planned and spontaneous - marriage, illness or childbirth! Most trainees take 2-3 months to prepare for Part I and 4-6 months for Part II.

The college syllabus should be used as a backbone for the revision timetable, checking off the areas that have been covered. The Basic Sciences Paper for Part II regularly astounds candidates, as the syllabus is so vast. There are several books devoted to techniques to assist in passing these exams (Williams/Trigwell (7) and Ben Green (8)), suggest a revision timetable and planning well in advance. One of the benefits of being a Defence Medical Services Trainee, is the ability to select training posts on a local scheme to suit ones needs as the examination approaches. For example, it may be possible to select a post with comparatively little on-call, a supportive consultant or a record of examination success.

### **Revision texts**

It is better to know all of a small book, than some bits of a big book. Examples of popular revision texts are Puri & Hall (9) and Buckley, Bird & Harrison (10). The former shamelessly follows the structure of the syllabus, the latter is more note-like. With the advent of the Critical Review paper, Sackett's Evidence Based Medicine (11), is a very useful text, although the examples are drawn from general medicine rather than Psychiatry. It is the belief of at least one of the authors, that the usefulness of a book is inversely proportional to its weight.

### **Reference Texts**

There are a number of great big books for psychiatry, which must be used as reference texts only. Two of the more popular books are

the *Oxford Textbook of Psychiatry* (12) and *The Companion to Psychiatric Studies* (13). Due to the time such books take to produce, they are not necessarily the most up to date sources of information.

### Classification

For both parts it is essential to be confident in using either ICD-10 (14) or DSM IV (15) disease classification systems. The preference is for ICD-10, with knowledge of the basic differences between the two. It pays to use the ICD codes in everyday practice, in order to become more familiar with the criteria.

### The Mental Health Act

A basic knowledge of the workings of the act is essential for Part I. For Part II a good knowledge of the main sections used, their applications and processes will be necessary. A basic knowledge of the forensic sections will also be needed. This can normally be obtained during daily clinical practice in the NHS setting but tutorials with one's supervisor and attendance at training days are recommended. The Maudsley publication "*The Maze – The 1983 Mental Health Act explained*" is most useful for this (16).

### Journals

Candidates should read the *British Journal of Psychiatry* reviews and scan the original papers, in particular the special supplements. This is of clear value in the examinations, especially Part II. The reviews provide a good basis for any essay and help one to keep abreast of current topics which often appear in the essay section and the clinical. The *Psychiatric Bulletin* can be equally stimulating and articles relating to examinations often feature (for example a series on critical review and evidence based medicine). Reading should not be confined to the clinical articles, this is a time of considerable change in psychiatry and the NHS, and candidates who are ignorant of any changes are likely to look foolish. (At the time of writing; The Human Rights Act, The Mental Health Act, Dangerous Severe Personality Disorder, the legal status of Cannabis and implementing the National Service Framework are among current issues). Other journals worth a look include: *Advances in Psychiatric Treatment*, the *British Medical Journal*, *The Lancet*, *Drugs and Therapeutics Bulletin*, and not forgetting appropriate sections of the *British National Formulary* (17).

### Courses

There are a number of courses available for both Parts I and II of the examinations, ranging from 1-day drug sponsored events to lengthy residential courses. One of the most popular residential courses "*The Guildford Course*" is held six monthly for both parts I

and II, and is based at Guildford University outside term-time. It lasts 7 –10 days and entails extensive lectures with hefty handouts, and mock exams including clinicals. The popularity and success associated with the course is such that most schemes will fund it. For Part II there is also a very good course run at St. Bartholomew's in London, focusing on PMPs and the long case, which is cleverly positioned after the written papers and just before the clinical. Birmingham also runs a good value part I and part II course. The British Association for Psychopharmacology runs a very useful one-day course twice each year for psychiatrists in training. Advertisements for most courses can be found in the *British Journal of Psychiatry*, BMJ and other journals and from one's clinical tutor.

### Passing the MCQs Element - Practice, practice and more practice!

Books are always useful. The volume based on Puri & Hall (18), is very popular, as is their revision text (9). The MCQ in Psychiatry series is also popular with separate books for Part I, Part II Basic Sciences and Part II Clinical Topics examinations (19,20,21). Circulated MCQs, rumoured to be penned by candidates with impressive memories, can give ideas for topics but would be more use with correct answers and explanations. There are some Drug Company sponsored packages which are of variable value. There is also an increasing amount of On-line resources including MCQs, candidate support, sample PMP's, recommended books and courses. The [www.MRCPsych.com](http://www.MRCPsych.com) site is well established, and has MCQs, help and details of many courses. Other useful sites can be found at the end of the article.

The college no longer employs negative marking for the MCQ papers, so one is foolish not to attempt all MCQs on the paper, as no marks will be gained for unanswered questions. Practising MCQs is essential, questions do turn up more than once, it also encourages candidates to dip into other reference texts (for example subspeciality references). It is useful to try to practice them as if they are negatively marked, in order to identify areas of weakness and strength. A paper per night as the examination draws near is as much as anyone can manage and the revision timetable should ensure that they are completed within the correct time limit.

Some authors advocate making up one's own MCQs in a study group in order to test each other. All the technique books give tips on how to interpret the wording (always, never etc.), and points will be scored by reading the questions carefully (they often sound impossible at first glance, very rarely

they are!). Mock examinations encourage familiarity with timing and procedure. It is essential to check that the answer sheet has been filled in correctly and that all the questions have been answered. In practice exams, errors should be studied. Is there a pattern? Is tiredness and boredom developing with worse results as the exam goes on? Is there a tendency to dive in too quickly without reflection? Is changing answers that were actually correct a problem because of over-reflection?

### Passing the Essay

For many of us, the Part II examination may be the first occasion on which one has had to write an essay since medical school. Practice is essential; courses may be useful too, especially in developing essay plan skills. The college has past papers which are available to order and these are a must in order to get an idea of the sort of question that might come up. It should be remembered that the essay tests the ability to debate topics, not just to regurgitate facts. A few relevant references for key subjects should be remembered, these can be from the College Reading list (available through the college), and from recent journals.

It would be a shame to score nothing for writing a great essay. Writing must be legible and in coherent sentences: marks are deducted for illegibility. Reviewing the last 18 months journals can often give an indication of the subjects to be raised. It can be a useful exercise to develop plans around these complete with references, since, if researched correctly they can often be moulded to answer the question in the exam.

### Passing the Critical Review Paper

The college has adopted Evidence Based Medicine with a passion, and introduced the critical appraisal paper in 1999. The college Seminar book was released before the introduction of the paper, has a number of worked examples for individual practice, and is presently in its second edition (22). Many courses now look specifically at this area and produce useful practice papers. Time is limited and it is essential that candidates get used to rapidly appraising papers and being able to make deductions from their content from the most basic of study designs to calculations such as NNT (a calculator is needed for the examination).

### Passing the Clinical examination

Clinical examinations need practice, and any avoidance must be overcome. Opportunities to gain examination practice should be sought out. It is best to approach different seniors for practice, ideally including at least one college examiner. SpRs who have recently passed are also a very useful

resource. It is advisable to consider asking SpRs or consultants who are not known personally to the candidate and not to avoid colleagues just because you think they will be hard.

Examination cases are often outpatients, although they can be inpatients, and are usually general adult, substance misuse, or old age in nature. The logistics of setting up an exam should be considered (candidates should always take the opportunity to get involved if possible). Floridly ill patients, and those who are unreliable, violent or under section are most unlikely to appear. This will obviously impact on the nature and degree of the clinical signs which can be expected.

The Clinical examination effectively tests the skills of the junior psychiatrist, but the examination can become problematic due both to anxiety and to difficulties conforming to the time restraints. Practice should always be in as exam orientated a manner as possible – not knowing the patient, limiting the time, and doing a presentation, preferably to 2 people, immediately after. It is strongly recommended that candidates practice to be able to complete the assessment in 40 minutes in order to allow the extra time to gather one's thoughts.

Candidates are often anxious about the portion of the examination when the patient is interviewed in front of the examiners but this can be countered by practising in front of others and preparing topics that candidates are likely to be asked to perform. Examples of such demonstrations are mood assessment, first rank symptoms, and cognitive assessment. Reference to *Cognitive Assessment for Clinicians* (23) is useful for brushing up any aspects of cognitive assessment that candidates may not perform on a daily basis, but which may lend themselves to inclusion in the clinical examination.

It is imperative not to avoid practising interviewing the patient in front of examiners; this is often the most anxiety-provoking element and needs maximum desensitisation. Interview skills training in small groups, using one's own videotaped interviews or role play, can be invaluable throughout training, and can be tailored to the exam (24).

Successful candidates generally employ good administrative skills in their favour. They use plenty of paper and write clear headings for each section of the interview. Sometimes this can be done whilst waiting for the patient to arrive. Only one side of the paper should be used and each sheet should be numbered. This avoids fumbling when in the examination room. The use of highlighter pens should be considered. Candidates should not feel that they have to spend all the time talking with the patient, it is often more useful to finish the interview early leaving time to formulate one's ideas and

opinions whilst the patient is present. This will enable the candidate to spot any areas which have been missed and to make the appropriate enquiries. Obviously this should be explained to the patient. It is important to brief the patient about the time which will be spent with them in front of the examiners since the more one can engage with the patient the easier the observed interview will be. Good management of time and careful documentation will pay dividends during the time spent with the examiners. It should be remembered that the candidate will have an idea of what the examiners might ask. Answers to such likely questions should be written down and thought through before going into the examination room.

When presenting, it is useful to be able to see a clock. Each candidate is responsible for ensuring that they keep to time and cover all the points they wish to before the examiners move on to the next section of the interview. Time keeping is often a difficult area at first and comes with practice.

There is a certain etiquette to be observed during the clinical examination, such as addressing the patient by their title and surname, introducing one's examiners, and obviously putting the patient at their ease. In one study 29% of patients found participating in clinical exams distressing, 38% said they would not like to take part again. It is likely that a patient will have to touch on sensitive areas in their histories which they may not have discussed for some time, and there is no substitute for clinical experience in managing this (25). During the observed interview the candidate is expected to start with open questions, control the information, perform the required task and display sensitivity towards the patient. There should also be the appropriate positioning of chairs to facilitate the interview. Seamless ability to do all of this only comes with practice and its importance should not be underestimated as candidates have failed the clinical on this aspect alone.

Unlike the written papers which are restricted to a number of sites, the clinical examinations are held at smaller centres throughout the United Kingdom. Measures are taken, using the information submitted on the application form, to ensure that candidates do not visit hospitals in which they have worked, or meet examiners that they have worked with or for. The clinical venue can be some considerable distance from home, so it is vital to travel up the day before the clinical examination and stay over night. The authors strongly recommend staying in the best hotel one can afford to ensure peace and quiet, and a good night's sleep. Excess alcohol and pungent food should be avoided the night before the examination. If time permits, a recon of the route to the examination centre is useful, but the college forbids visiting the hospital prior

to the examination. Knowledge of the route and arriving in good time will reduce anxiety and allow the candidate to focus on the examination. Equally it is important not to arrive too early – protracted pre-exam discussion with peers can be anxiety enhancing too.

It is important to ensure by checking the college details that the correct examination site is being attended. One city may contain many examination sites and they can sound similar.

### **Patient Management Problems**

PMP practice is also invaluable, again using as many sources as possible. SpRs rarely forget the PMPs they met in battle, and are usually keen to share their war stories. During the examination two examiners present about 4-6 problems over the 30 minutes and these are usually from their own clinical experience. The information one receives can be given all at once, or with further questions as the problem progresses. It is essential to listen carefully; jotting things down is acceptable but risks missing information. Candidates will have managed difficult cases professionally so there is no need to be put off. Important issues raised by the case should be stated and the answers should be structured. The examiners are testing judgement, structuring offers clarity for both candidate and examiners. All the risk assessment areas must be covered. The examiners are looking for a candidate who they would feel they would be happy to leave in charge of their firm when they went on leave. The evidence base for management choices should be discussed where possible, otherwise it is better to be honest and state how the necessary information might be found. Candidates should be guided by the examiners, if they have mentioned an area the candidate has not thought of it might be prudent to go down that route!

Again practice is paramount in order to get used to talking through one's assessment, impression and management of a case in a coherent pattern without too much repetition (the quickest way to irritate the examiner!). PMPs should be practised either in mock exams, on courses, or with those who have had recent experience or with one's supervisor. There are some good courses as previously mentioned as well as books with examples for practice. Common issues include: risk to self or others, capacity and consent, The Mental Health Act and The Children's Act, involving other agencies (social services, education, carers), treatment resistance (Maudsley Guidelines are useful), compliance, ethics. Psychiatric patients in A&E are also good examination subjects.

### **Study Groups**

Although it is important to accept some degree of social isolation while revising,

there is value in working in small groups, meeting once or twice a week, for support and division of labour, but one must be wary of intellectual loafing. Study groups are a good way of judging how one is doing with one's revision by comparison with the other candidates group. It is important to be wary of very clever, arrogant or the over anxious candidates within the group, they may undermine confidence if too long is spent with them.

### Conclusion

Candidates should get the application in on time, plot a revision timetable, stick to it, cover the syllabus, consider working within a study group, practice aspects of the exams, remember to have a life, do some exercise, walk the dog, and speak to their friends and family.

The Defence Medical Services offer a particularly good environment in which to be tackling these exams; they are supportive of study time, allow training to be tailored to individual needs, adhere to the College requirements, fund one attempt at each part of the examination, fund attendance at an approved MRCPsych course (all the authors were in attendance at the University of Leeds MMedSc in Clinical Psychiatry), and have funded all other courses requested within each individual's extensive training budget.

Good luck!

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  - Seminars in Basic Neurosciences, Edited Morgan E & Butler S. Gaskell
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### Useful Addresses

The British Association for Psychopharmacology Office, 36 Cambridge Place, Hills Road, Cambridge.CB2 1NS. Web Site: <http://www.bap.org.uk>

BBR Medical Education (Parts I & II), 82 The Maltings, Roydon Road, Stansted Abbots, Herts, SG12 8HG. [Admin@bbrmedicaleducation.net](mailto:Admin@bbrmedicaleducation.net)

Guildford MRCPsych Revision Courses, Mrs E C Denning, Belmont Postgraduate Psychiatric Centre, Sutton Hospital, Cotswold Road, Sutton, Surrey, SM2 5NF.

### Recommended reading

Taylor D, McConnell H, Duncan-McConnell D *et al*. The South London and Maudsley NHS Trust 2001 Prescribing Guidelines. 6th Edition. Martin Dunitz. 2001.

### Websites:

These are just a selection of what's available, run a search on [www.GOOGLE.com](http://www.GOOGLE.com) entering MRCPsych examination for full scope of what's there!

- MRCPsych website – run by organiser of Birmingham course:  
[www.mrcpsych.com](http://www.mrcpsych.com)
- MCQs & lots of links:  
[www.users.globalnet.co.uk/~drakb/psychiatry.html](http://www.users.globalnet.co.uk/~drakb/psychiatry.html)
- PART I MCQs:  
[www.rsm.ac.uk/pub/bkmathews.htm](http://www.rsm.ac.uk/pub/bkmathews.htm)
- MRCPsych Q&A's:  
[www.omni.ac.uk/whatsnew/detail/30124.26.html](http://www.omni.ac.uk/whatsnew/detail/30124.26.html)
- Psychiatry Trainee Forum:  
[www.pol-it.org/psychtrain.html](http://www.pol-it.org/psychtrain.html)