Electroconvulsive therapy: College guidelines

Sir: Brookes *et al* (*Psychiatric Bulletin*, September 2000, **24**, 329–330) report "a slight improvement in the proportion of electroconvulsive therapy (ECT) treatments considered therapeutic" following implementation of a dose titration protocol as recommended by the Royal College of Psychiatrists. Unfortunately their interesting paper did not include a statistical analysis. Comparing the proportion of therapeutic fits before and after the changes to administration (131/213 cases, 62% *v.* 92/132 cases, 70%) yields a non-significant finding using the chi-square test (χ^2=2.39, d.f.=0.12).

However, ECT treatments where the fit duration was considered too short (under 20 seconds) did fall (from 79/213 cases, 37%, to 21/132 cases, 16%) and this result is highly statistically significant (χ^2=17.8, d.f.=1, $P<0.01$, difference in proportions=21%, 95% confidence limits 12–30%). This backs up the authors' assertion that College guidelines reduced the likelihood of sub-therapeutic stimulations at the expense of increasing the number of prolonged (>50 second) fits.

Although statistical significance is not the same as clinical significance, papers that report on practical service developments will be strengthened by an appropriate analysis. Statistics can enlighten as well as frighten!

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ECT audit

Sir: I read with interest the audit on ECT practice (Brookes *et al*, *Psychiatric Bulletin*, September 2000, **24**, 329–330) and would like to express my appreciation of this important piece of work. As you know, ECT practice is one of the most empirically-based interventions in mental health practice with established efficacy and is nevertheless one of the most controversial, particularly in the public domain. It is also the one area where we have now produced guidance, albeit guidance that is due for review and updating. It is essential that where explicit standards exist, the audit process is implemented at local level to ensure that optional standards are achieved. There is little justification for the present variation in psychiatric practice in the administration of ECT in the face of such clear guidance. This audit and its impact is an example that should be followed elsewhere. The audit process is key to improving practice at local level and we should encourage, as a matter of policy, the publication of many more examples of effective clinical audit.

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the college

Forthcoming changes to the MRCPsych examinations

MRCPsych Part II examination: use of the written papers as a screening examination

In December 1999 the Court of Electors agreed that, with effect from autumn 2001, the written papers in the MRCPsych Part II examination should act as a screening examination. This will mean that only those candidates who reach a satisfactory standard in the written papers will be eligible to proceed to the clinical examination. It was not considered in the candidates' best interests to undertake an examination from which they would receive no benefit in their final examination result.

(a) The use of the written papers as a screening examination will be implemented at the Part II examination in autumn 2001. At present candidates are required to take three written papers: a multiple choice question paper, an essay paper and a critical review paper. From autumn 2001 only those candidates who pass at least two written papers, and who reach a permissible standard in the third paper, will be eligible to go forward to take the clinical examination. Those candidates who are eligible to go forward will receive notification of this in writing, but will not receive feedback on their performance in the written papers prior to the clinical examination.

(b) All candidates entering or re-entering the Part II examination from autumn 2001 will be allowed unlimited attempts at the written papers until they have exhausted their maximum number of attempts at the clinical examination. No time limits apply to the period within which all permissible attempts must be completed.

(c) Candidates will be permitted a maximum of FIVE attempts at the clinical examination. There will be no transitional arrangements, so those candidates who have already completed a number of unsuccessful attempts under the current regulations will have a corresponding number of attempts deducted from the five allowed at the clinical examination under the new arrangements. Therefore, for example, those candidates who have failed the Part II examination on two previous occasions will be permitted only three further attempts at the clinical examination. These arrangements apply irrespective of whether the previous failure was in the written papers or in the clinical component of the examination.

(d) Those doctors who have exhausted all possible attempts at the Part II examination under previous regulations will be bound by the regulations in operation at that time and will not be allowed to re-enter the Part II examination.

(e) At present, candidates are required to pass the clinical examination and achieve an overall aggregate of at least 50% based on their performance across all elements of the examination. From autumn 2001 candidates will not be required to achieve an overall aggregate mark, but will be required to pass the clinical examination. Thus, those candidates who progress to the clinical examination and pass it, will pass the examination overall. However, those candidates who progress to the clinical examination and fail it will be required to re-enter all components of the examination at their next attempt.

(f) In order to allow sufficient time to process the results of the written papers, and to allocate the successful candidates to clinical centres, the time period between the two parts of the examination will be increased to 6–7 weeks, with the written papers being scheduled slightly earlier than at present.

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