obtain in psychiatry. To overcome this difficulty the following plan of action is suggested.

The College should consider re-introducing the DPM or equivalent qualification such as DRCPsych, to enable trainees to have more options open for them to obtain relevant qualifications. Most of the Royal Colleges in the UK conduct alternate examinations, other than Membership, and award appropriate qualifications.

How to implement it

At the present time all candidates must pass the Part I MRCPsych examination before they take Part II.

At the first attempt for Part II candidates can appear for the whole examination.

If the candidate passes some parts of the examination and fails the remaining, he should be given two options:

(a) to re-appear for the whole examination in order to obtain MRCPsych

(b) opt to hold the parts in which he/she passes and to re-appear only for the parts in which he/she failed. After passing all the parts the candidate would be awarded DPM or DRCPsych.

Once the candidate opts to take the examination in separate parts there should be no limit to the number of attempts made to complete it. After completing three years of approved training there should be no need to be in a training post to take subsequent examinations.

Those who are awarded DPM or DRCPsych should be allowed to continue as inceptors of the College.

This provision would not belittle the standard and quality of the Membership examination. In fact more doctors would continue in psychiatry and, even if they opt to become family doctors, they would be able to obtain a psychiatric qualification, which in turn would improve health care in general.

V. M. MATHEW

University of Leicester
Clinical Sciences Building
Leicester LE2 7LX

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DEAR SIRS

Dr Mathew makes a number of points.

With regard to overseas doctors it is true that if they are limited to four years in the United Kingdom, in line with current immigration policy, they may not be able to make the full number of attempts allowed in Part I and Part II of the MRCPsych. It should be pointed out, however, that those overseas doctors now coming to the United Kingdom are a different group to those studied by Dr Bhate, and by no means all wish to take the MRCPsych examination.

Posts approved for training are constantly monitored by the College and applications for new posts carefully considered. Changes to the Regulations have recently been published. The College accepts that there is a need for continuing education of all doctors: not only for the MRCPsych but also those doctors not in training grades, such as staff grade posts. A number of doctors occupying staff grade posts have been deemed eligible to sit the MRCPsych examination, but this is approved on an individual basis. To gain approval, it is necessary for these doctors to have the same range of training opportunities as those in training posts; for example, that they may obtain experience in sub-specialties of psychiatry. This clearly needs the cooperation of employing authorities.

It is also true that, in the UK at the present time, there is no alternative psychiatric qualification. The question of reintroducing the DPM (which was never administered by the College) or an examination of similar status has been considered at intervals over the years and is currently being reconsidered. Such an examination would be a major undertaking and would involve considerable expenditure of resources – both personnel and financial – and it would be important that such resources were not diverted from plans to improve the MRCPsych examination. The MRCPsych examination has been carefully designed and is constantly monitored by the elected representatives of members of the College sitting on the Court of Electors. It is felt at present that, although there is always room for refinement, the MRCPsych examination fulfils its main purposes of confirming that a doctor has reached a sufficient standard of competence to become a Member of the College, is seen by the public to have reached such a standard, and is ready to enter higher training. Any change would have to be fair to those already holding membership and not diminish the qualification.

Dr Mathew puts forward interesting ideas about offering candidates who fail two options. We believe the procedures involved would be very cumbersome, very difficult to organise, and expensive. These or similar proposals could, however, be considered.

Overall, we are not sure how helpful it is for a candidate to be encouraged to make unlimited attempts at *any* examination, or how fair this would be to candidates who succeed within the first few attempts, or to patients for whom the fact that the doctor treating them possesses the qualification is important. In practice, we believe it would be

difficult to pass such a clinically based examination without recent experience in a training post.

SHEILA A. MANN, *Chief Examiner*
FIONA CALDICOTT, *Dean*

A register of Munchausen cases

DEAR SIRS

Lovestone employs several arguments against the use of a national register for psychiatric Munchausen cases (*Psychiatric Bulletin*, September 1991, **15**, 581). The most cogent of these is that such a register might constitute a breach of confidentiality. In order to protect confidentiality the register would need to be accessible only to medical staff.

It was suggested that the use of a register is unnecessary for the diagnosis of Munchausen's syndrome. In the case I described (*Psychiatric Bulletin*, March 1991, **15**, 167) the diagnosis was considerably facilitated by referring to a Social Services list of "hospital hoppers". More recently I have encountered a case of an aggressive and suicidal man, apparently aged 14, who described a variety of psychiatric symptoms and who gave a history of having received depixol injections. He refused to give his home address. After admission to an adult psychiatric ward followed by a local authority children's home, he is now in a Social Services Secure Unit. It is still unclear whether he has given his true name and age and whether his psychiatric symptoms are genuine.

The assertion that making a diagnosis of Munchausen's syndrome is not helpful since there is no known treatment is surprising. Surely the recognition and documentation of a poorly understood syndrome is a pre-requisite for research into treatment and outcome. Any such research would be facilitated by a national register of cases.

Although Lovestone dismisses the economic benefits of a register these are nonetheless important both in hospitals and in local authority children's homes where there is considerable pressure on bed space. Hospital admission is not only costly but potentially harmful. Repeated admission is likely to reinforce the hospital "addiction" and may be associated with the administration of psychotropic medication which is not without its harmful effects.

My interest in a register is not the result of a fear of being "conned". I do not suffer from an overwhelming urge to consult a register when dealing with patients presenting with somatisation disorders, dissociative disorders or deliberate self-harm. It is the role of the psychiatrist to look beyond the presenting signs and symptoms to the underlying distress and personal dilemma of the patient.

R. I. DAVEY

Clatterbridge Hospital
Bebington, Wirral
Merseyside L63 4JY

Use of the Mental Health Act 1983

DEAR SIRS

I read with some disquiet the letter from Dr Azounye (*Psychiatric Bulletin*, July 1991, **15**, 455) concerning use of the Mental Health Act 1983. I am extremely uncomfortable with the idea that legislation which has been framed to protect the civil liberties of psychiatric patients should be modified to "make life considerably easier" for psychiatrists and social workers.

Section 3 of the Act contains a very important safeguard for the patients, providing for consultation with the nearest relative. This allows the patient and his family more say in the process of compulsory admission. By admitting someone on a Section 2 this is negated. It is perfectly possible to discharge a patient from Section 3 in less than 28 days, should the patient's clinical condition dictate this.

Section 2 is framed to allow detention under less rigorous conditions in a situation in which the patient is less well known by the clinical team. Where the clinical team has extensive knowledge of the patient and, conversely, the patient and his family have knowledge of the benefits accruing from previous psychiatric treatment, then it seems essential that increased safeguards continue to apply. This view would appear to be endorsed by the Code of Practice (1990), paragraph 5.4 which states that decisions should not be influenced by the duration of proposed treatment.

In addition, where a patient is well known to services, should not the treatment plan be formulated while the patient is in the community and offered without recourse to hospital admission?

JON KENNEDY

Reaside Clinic
Bristol Road South
Rubery, Rednol
Birmingham B45 9BE

Reference

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Impact of the White Paper on Specialist Services: the Cassel Hospital Survey of Referrers

DEAR SIRS

Dolan & Norton's findings on clinicians' views about the changes in usage of specialist services such as the Henderson Hospital (*Psychiatric Bulletin*, July 1991, **15**, 402–404) are confirmed in part by the results of the Cassel Hospital Survey of Referrers. The Cassel Hospital has a slightly different remit to