that the short answers paper and clinical vignettes are more alien to the majority of medical graduates means similar attention to all aspects of the exam may well be profitable.

Obviously, there is no substitute for an adequate level of knowledge, which is presumably to be gained from studying the major post-graduate textbooks and selected key references. The Examiners state the MCQ content is derived from uncontentious material available to all trainees but do not detail these sources. A member of the Collegiate Trainees' Committee informed me that a member of the Examinations Committee had told him that all the relevant information could be gleaned from the *Edinburgh Companion*, the *Oxford Textbook*, Hildegard & Atkinson's *Psychology Test*, McGuffin's *Scientific Basis of Psychopathology* and the regularly updated *Current Opinion in Psychiatry*. The College would do well to substantiate or refute such rumours, perhaps by providing an authoritative exam reference syllabus.

Dr Smith's suggested study technique is an especially valuable contribution. As he says, reading textbooks and key references while thinking what MCQs could be derived from the material can alert one to potential questions and identify areas that probably cannot be examined in MCQs, that are perhaps more likely to be tested in other parts of the exam. It also provides a much needed novel way of revising and allows candidates to appreciate some of the difficulties facing Examiners. There is at least one MCQ book, that accompanies the *Edinburgh Companion*, that demonstrates this process.

As well as practising MCQs oneself, candidates can gain from doing so as part of a study group where the opportunity to discuss how others generally approach MCQs and answer specific questions can be very illuminating. Similar benefits can accrue from practising short answers, clinical vignettes and even the clinical examination in such a setting. A study group also provides some 'group supportive psychotherapy' in assuaging anxieties as the exams loom.

It is, of course, important to attempt past papers and a lot of people find MCQ tests invaluable. There is a glut of these on the market so people can afford to be selective about which one to use. Ideally, such a test should provide one with a detailed explanation of an MCQ answer, preferably with a reference. Those texts that merely give questions and a true/false answer give little information on how to approach them while further depleting financial resources at a time when many can ill afford it! Finally, there is at least one drug company (Dista) that can offer computerised MCQ experience if requested.

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DEAR SIRS

I read Bisson's article on the MCQ (*Psychiatric Bulletin*, February 1991, **15**, 90–91) with a sense of *déjà vu*. He described exactly my irritation when I took it. My own method was to answer the questions on the basis of how I thought the then Chief Examiner would answer them: on at least two questions on defence mechanisms and ethanol-induced brain damage this resulted in a different answer to the one I actually thought was correct.

Since I passed, this must not have been a totally erroneous strategy. Perhaps MCQs do not test what you know but who you know?

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Soviet psychiatry

DEAR SIRS

Over 18 months have elapsed since the decision of the Athens Congress to re-admit Soviet psychiatrists to the WPA (Bloch, 1990). It appears that psychiatric abuse in the Soviet Union has been ameliorated but not eliminated. Most 'political' patients have been discharged and a million names have been removed from the Psychiatric Register. The Supreme Soviet imposed regulations on psychiatric treatment in 1988, making wrongful detention a criminal offence. Responsibility for the infamous high-security SPHs has been transferred from the Ministry of Internal Affairs to the Ministry of Health. Psychiatric abuse has been openly criticised in the Soviet media, and the authorities have shown a noticeable willingness to allow dialogue with foreign psychiatrists.

Optimism over recent improvements must be tempered by scepticism, as Koryagin (1990a) insists. Structural changes have been limited and, despite overtures to the contrary in Athens, leading Soviet psychiatrists continue to deny that any abuse ever took place. Though lower in public profile, those senior psychiatrists most closely identified with 'political psychiatry' have yet to be displaced from office and hinder further progress.

Unlike its neighbours in Western Europe, Russia was transformed from a largely feudal to a Socialist command economy in the years after 1917, without the development of capitalism or the establishment of liberal democratic structures enshrining the rights of the individual in law. The question of civil liberties in the USSR remains vexed, with obvious consequences for any attempt to redefine the limits to compulsory treatment (Koryagin, 1990b).

Although Soviet psychiatry was cynically abused for political purposes over many years, outrage must be qualified by knowledge of the relatively small scale on which this took place and the brutality of earlier means of repression. The history of the USSR this

century has been turbulent; where Stalin's repression helped weld together a nation state, Gorbachev's reforms look like heralding its disintegration. In the case of psychiatry, structures legitimising repression have not been fully expunged, offering scope for future restoration in the event of a political backlash. In particular, we must register the parlous state of the Soviet economy, and the continuing impoverishment of the health services in general.

Western psychiatrists continue to face a dilemma: whether to welcome dialogue with Soviet colleagues, or to press for an extension of sanctions until fully satisfied that structural changes have taken place. Most Soviet psychiatrists have never been involved in political abuse, though they and their patients continue to suffer the physical and intellectual privations forced upon them by the system in which they live. It is time to roll up our sleeves; our Soviet colleagues need more than our blessing. If we are to transcend Cold War rhetoric we must offer something more tangible: scholarships, educational exchanges and open academic discourse would be limited but realisable goals.

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The patient's perspective

DEAR SIRS

It is heartening that British psychiatric researchers are at long last seriously addressing the patient perspective (Ballard & McDowell, *Psychiatric Bulletin*, November 1990, **14**, 674–675). The recent *People First* national survey of psychiatric patients conducted by MIND in collaboration with Anne Rogers and myself at Roehampton Institute will be providing more extensive information of this type in 1991. Could I make three comments for consideration by practising psychiatrists and the Royal College of Psychiatrists at this stage?

First, our findings on perceived helpfulness of medical and nursing staff are less complimentary than the Coventry study. The latter cites satisfaction levels of 90–98%. Our study will cite in the region of 54–57%. Second, we also found substantial concern about informed consent. Ballard & McDowell address this issue but then repeat the profession's conventional wisdom of striking a balance between information giving and avoiding "necessary worry to the patients". This unsatisfactory compromise must be seriously addressed by the profession. Most physical treatments, especially major tranquillisers, can have very powerful iatrogenic consequences, which are risked in every case prescribed. The Mental Health Users Movement (Rogers & Pilgrim, 1991) is justifiably demanding a full and honest debate about the risks of treatment. Third, why is the potentially distressing and humiliating experience of "ward rounds" still considered good practice in psychiatric settings? (See also the letter from Dr White on *Talking to Patients* in the same issue.) Who benefits from them? Should this anachronistic ritual, which seems mainly to have existed to massage the egos of psychiatric showmen and pedagogues, be re-negotiated with representatives of users or services in each locality?

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see pp. 363–364

Psychiatry in South Africa

DEAR SIRS

The recent report to the President by Dr Caldicott and her colleagues (1990) on their visit to South Africa is helpful and informative. However it does not go far enough in its recommendations regarding the Society of Psychiatrists of South Africa.

The SPSA represents about half of all South African psychiatrists but has failed to utilise this unique position to any effect. They have been consistently lethargic in their efforts to promote an efficient mental health care system for all South Africans. Further, they have failed in their training of future psychiatrists. In my two years as a registrar in the 'black' hospitals of Hillbrow and Baragwanath, I received no communications or directives from the SPSA.

At least 50% of SPSA members are engaged solely in private practice, offering the sort of care that is inaccessible to the vast majority of South Africans. It is hardly surprising therefore that the SPSA is nothing more than a perfunctory organisation. For its members to lobby for development of a national health care system would conflict with their private practice interests. Psychiatry in South Africa needs