Examining the examiners

SIR,—Your interest in postgraduate medical examinations (Feb 24, p 443) deserves repayment by an outline of what this college is doing to ensure the competence of its fellows. The examination system is only one component; others are the inspection and recognition of hospitals for training and the organisation of postgraduate educational activities. The College of Anaesthetists has been trying for some time to "de-mystify" its examinations, and is about to publish a comprehensive training and assessment guide for candidates. It has also done a survey of all candidates presenting in 1988 for the final part of the examination in an attempt to identify common causes of failure; this will be published in the *British Journal of Anaesthesia*. Although some criticisms emerged, notably in relation to the method of announcing the results, an average of 92% of candidates who responded were satisfied with the arrangements for the four elements of the examination.

The College uses multiple choice questions (MCQ), written answers, clinical examinations (with or without real patients), and oral tests. Their use is constantly refined, increasingly structured formats being used to improve standardisation and reliability, but the overall mix of the methods of assessment is, we feel, basically correct. The MCQ is probably the most objectively reliable test, but has poor validity in terms of the assessment of competence to practise anaesthesia, intensive care, and pain relief. It is a good way of placing candidates in rank order, but the temptation to use norm referencing has to be resisted. Discriminating questions, whose previous performance is known, are used to compare candidates with previous cohorts and to draw grading bands. Written answers, clinicals, and orals are probably the more valid for assessing competence. Although they are less objective they can be made acceptably reliable by careful structuring and training of examiners. The performances of all parts of the examination and of individual examiners are carefully audited. The objectively structured clinical examination, increasingly used at undergraduate level, is being actively considered by this College.

Your suggestion that the improving quality of medical school entrants should be reflected in improved pass rates fails to take into account doctors who may not be intellectually able to pass our fellowship examination but who sit it repeatedly. The College of Anaesthetists does not limit the number of attempts and some candidates have sat our final examination twenty times. In 1989 we introduced a maximum of six attempts at the part I, with compulsory counselling after four.

Pass rates, which are published, are rising but are probably still too low, and they can best be improved by attempting to match training to assessment. It is important to ensure that criteria are closely related to clinical competence; selection processes must be adequate and clinical experience must be satisfactory; trainers must be trained and given as much information as possible about the standard of competence required.

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Unsigned editorials

SIR,—Your Feb 24 editorial on Royal College examinations has attracted attention, in part because of the apparent paradox that while calling for greater openness from the colleges, the editorial itself was unsigned. The whiff of hypocrisy makes an easy target for superficial criticism, and merits a rehearsal of the arguments for unsigned editorials. The principle of not signing editorials is well recognised in newspaper journalism; do critics who read *The Times, Guardian,* or *Daily Telegraph* complain to the editors of those papers about anonymous editorials?

The President and chief examiner of the Royal College of Psychiatrists (March 24, p 730) confuse an editorial with a signed paper. These beasts are of different species. Papers are unsolicited, whereas editorials are commissioned. A paper carries the personal views of the authors, and its substantive content is not edited. An editorial represents the persona of the journal, and the original draft may be substantially altered by the editor. Editorials and papers also differ for the writer. Signed papers are attributed to the author, who receives credit in forms such as the citation rate; the principal reward for an editorialist for what can be a large amount of work is the private knowledge of a job well done. Anonymity may sometimes result in abuse—but that is not unknown in signed articles. Nor should it be assumed that when reading an unsigned piece the staff of *The Lancet* immediately take leave of their critical faculties and publish anything that flops through their letterbox. Indeed since the journal's reputation partly depends on its editorials they are perhaps considered more carefully than signed papers.

Why do those wishing to know the identity of editorialists need that information? The truth or falsity of a argument does not depend upon the person stating it. Knowledge of identity only deflects from the important questions and allows potential *ad hominem* criticism. "Hunt the author" is a popular party game, but must not be confused with serious discussion. When Richard Wakeford, who has a special interest in medical education, criticised in a signed piece the quality of the Society of Apothecaries' examinations[1] the Master noted "Criticism of our examination is particularly resented when it comes from a medically unqualified and uninformed source"[2] while another correspondent began his letter with "Who is Richard Wakeford . . .?.[3]

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Homeless and mentally ill

SIR,—The high prevalence of mental illness amongst the homeless is well established.[1,2] However, the debate on how best to respond seems to have become sidetracked into a re-evaluation of community care.[1,3,4] This misses the point: the homeless mentally ill constitute a large group lacking access to a full range of psychiatric services flexible enough to respond to their needs. These services receive little or no specific funding for the homeless because resources are allocated on the basis of census information.

Under the new provisions of the government white-paper every district health authority will receive an allocation to provide a service for its own residents.[5] Residency will be determined by the patient's own perception of where he or she is currently living or, if homeless, was last resident. A purely subjective definition will thus carry significant funding implications.

We have done an audit of an acute inpatient service on one day last month. All acute psychiatry wards in an inner city district were visited by N. R. F. who collected data on age, sex, working diagnosis, mode of referral, and residential status. Of the 87 inpatients 33 (38%) had no permanent UK home. Interviews revealed that on the new residency criteria, 10 of these 33 would become the financial responsibility of another health authority, 11 would continue under the current authority, 3 were foreign residents, and 9 could not give a specific reply, "London in general" being a typical response.

The homeless group tended to present with severe psychotic illness as emergencies—via the accident-and-emergency department, admissions under the Mental Health Act, or from the criminal justice system (table). These modes of referral for severe illness imply that the services providing early intervention and aftercare for the resident population have little impact on the homeless group. Nor is there much incentive to improve the service to the homeless for to do so might uncover even greater need and place yet more strain on services to the local resident population.

Psychiatric services to the homeless are ignored in most funding calculations. The white-paper proposals go some way towards finding a solution but the rules may be hard to implement and vulnerable patients may find themselves under pressure to give the "right" answers. Moreover, a significant group of long-term homeless mentally ill cannot recall a place of last residence. The