Personal Paper

How to pass the DCH

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Having both failed and passed the DCH examination in the past 12 months, I feel able to offer a few words of advice to prospective candidates.

It is useful to have a broad idea of the nature of the examination. It is not a test to be taken after a casual browse through a friend's textbook. It is a demanding diploma which, for that reason alone, may be rewarding for the well-prepared. There is ample opportunity to air knowledge assiduously acquired. Many of the candidates are training paediatricians, which presents problems for the trainee general practitioner who has spent only six months in the specialty. This becomes apparent when the boys stroll over from Great Ormond Street and sit beside you in the waiting room discussing interesting cases of medulloblastoma. Do not be dismayed, however, since I saw several of them six months later.

What to read

The examination is mainly academic. The colleague with the photographic memory will sail through whether or not he can tell one end of a baby from the other. It is therefore best to prepare from textbooks. Hutchison's *Practical Paediatric Problems* is unfortunately the usual book. I find this a drab account of a lively and interesting subject. Anyone sharing my distaste may enliven revision by collecting articles from the *British Journal of Hospital Medicine*. These review articles are concise, up to date, and stimulating because they are written by experts. Topics covered over the past five years are extensive, but gaps must be bridged with Hutchison's book. The answer to every multiple-choice question (MCQ) will be found somewhere in the depths of this venerable text. The approach to the subject used in Illingworth's *Common Symptoms of Disease in Children* is very useful, particularly in the short cases and viva voce examination. His differential diagnosis, however, is too long for this occasion. Nixon and O'Donnell have written a splendidly down-to-earth account of paediatric surgery; Vulliamy's book on neonates and Illingworth's slim text on developmental assessment are also compact and adequate for the task in hand. I regard all these books as essential reading for candidates taking the DCH.

Other books that add interest to the subject are *Heart Disease in Paediatrics* by Jordan and Scott, and the review articles in *Recent Advances in Paediatrics* (especially the account of renal medicine) and *Recent Advances in Paediatric Surgery*. A browse through a dermatology book, a short ENT text, and Smith's *Recognizable Patterns of Human Malformation* will pay dividends.

Finally, the leading articles on paediatrics in the *BMJ* and *Lancet* are worth careful study, and the excellent BMA booklet *Problems of Childhood* is compulsory reading.

The list of textbooks may seem daunting, and the clever candidate may pass after reading a lot less. As a pedestrian candidate troubled by mumbling, examination nerves, and a tendency to panic, I can confidently say that the second time I took the exam, after reading these books, I felt happy to tackle any case presented to me.

Written exam

The examination begins with a two-and-a-half-hour short-answer section. Remember, there is ample time—about seven minutes—to plan the 100-word answers, which should thus be legible and ordered, and include as many key phrases as possible. Questions are phrased carefully. If the examiners ask for clinical presentation they do not want to know about treatment. Remember that all 20 questions score equal marks, so that scant attention to the more abstruse questions is inadvisable. In this section there is a rather inappropriate attempt to include some community paediatrics; writing short notes on such subjects as sexual education for the handicapped is rather a tease to the imagination. Poisoning, behavioural problems, and infectious disease are common topics. It is probably worth incorporating a few jokes, as some of the examiners are only human.

There is a pause for lunch. May I recommend abstinence?: diplopia and headache are troublesome when ploughing through the MCQ paper. On both occasions when sitting this part of the examination I had to resist a strong urge to walk out, deface the paper, or make a rude noise. I had, of course mistakenly believed that the DCH was intended for general practitioners interested in paediatrics. On the contrary, in this exam are found the obscure syndromes, ambiguous questions, finicky details, academic chestnuts, and endless questions on those mind-boggling inborn errors of metabolism. Are the maxillary sinuses well developed at birth? Is there a cataract in histidinaemia? What is the normal blood phosphate? When does the asymmetrical tonic neck reflex disappear? More to the point, Who cares, when you could quickly look it up in a book? Success in this section depends on close observation of the other candidates; the girls are on the brink of tears, some of the lads leave early, and that chap from Great Ormond Street is deep in thought, sucking his pencil or picking his nose. I can assure all candidates that the pass level must be extremely low, as I passed this section on both occasions.

Clinical exam

Then follows a dreadful gap of 10 days when all that valuable knowledge with an ultrashort half life is fading away. Examination Hall is a terrible and gloomy place full of cobwebs, dusty

smells, and flaking paint. The trip may easily be turned into a nightmare by staying in one of the local boarding houses, where the night before the exam may be spent wondering whether that creeping feeling in the legs is imaginary or not. After a cold, coagulated breakfast there is a windswept stroll to the hall. The waiting room is comparatively sumptuous, since it is dusted yearly, and sports an enormous paper lampshade, which hangs ominously over the assembled gathering. Ignore the fellow trying to incite a stampede by reciting obscure cases.

The clinical exam is rushed. There is 20 minutes to prepare the long case. Two minutes commiserating with the patient or gossiping with mum is well spent, as both, once in a sympathetic mood, are an endless source of inspiration. "Don't forget the clubbing," mum said just before the examiner whipped back the curtain. I could have hugged her. Consider the investigations and differential diagnosis during your 20 minutes. The questions asked are searching and intelligent. Some of the cases are obscure—congenital agammaglobulinaemia, Hand-Schüller-Christian disease, and rubella-induced thyroiditis to name but a few. Simpler cases such as cerebral palsy, mongolism, spina bifida, mucopolysaccharidosis, hepatosplenomegaly, and cystic fibrosis are all firm favourites. Short cases are either spot diagnoses or easily detectable clinical signs. Birth marks, goitres, and the phakomatoses may appear. Do not be put off by an aggressive examiner. He may have been bullied at school or just had a row with his wife. More likely, he will be a specialist with little paediatric knowledge outside tertiary hyperparathyroidism in neonates. If your dazzling developmental assessment fails to impress do not proceed with the account, as he is probably a surgeon and you will make him feel inferior.

Steering the discussion is a complicated skill consisting in casually mentioning topics about which you know a reasonable amount. As the somnolent examiner awakens he grabs for his next question, "You mentioned Krabbe's leucodystrophy. . . ." Similarly, do not irritate the examiner by being too smart. Answer the questions at a reasonable pace, but not too quickly, as otherwise this interferes with his interquestion nap. Ten minutes is allowed for the long case discussion and 10 minutes for the short cases. Refuse to examine bawling infants who do not respond to your gentle ministrations. Finally, do not be

afraid to plead ignorance; do not waste time bluffing, as this creates a bad impression.

The afternoon viva voce lasts for 20 minutes, and there are two examiners. High-risk topics include purpura, rickets, gastroenteritis, and intersex states. Some candidates were asked about the Court Report, electrolyte distribution in the neonate, and other dismal matters. Normal values, drug dosage, and formulae for fluid balance are asked, and *A Paediatric Vade-Mecum* is therefore well worth studying.

Results

The results are out within a few days. Either way it is depressing, since there is a £20 penalty for passing. If you fail first time, write to find out which sections you failed and have another go. There is always good and bad luck. At my second attempt I had the same examiner who had failed me before. On the second occasion he behaved like a perfect gentleman. We had a benign chat, and he even laughed at one of my jokes.

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STRANGE ENCOUNTERS

References—procedure for candidates

Unsupervised clerks, new to the work, may not know how to distinguish between candidate and referee, but candidates, too, often suffer from lack of supervision and of guidance on procedure. They commonly do not know how to refer to their referees if their application has to take the form of a letter instead of following the reasonably clear requirements set out on the printed application document that many employing authorities nowadays usually insist should be used.

A great many candidates for medical jobs are incapable of writing suitable letters and this is as much a justification for the obligatory use of application forms—with their printed headings and guidelines—as the deficient literacy of candidates for higher medical qualifications is a justification for replacing the conventional written examination by the multiple choice question paper.

Some quotations from applicants' letters hint at the range of phrasing that their uncertain understanding of the referee system commits them to: the importance of such errors of style or tact is that some members of appointments committees are themselves still so immature that, having found a candidate's infelicity of statement to be laughable, they assess his suitability for the job under consideration not by his professional worth but by his inexperience in matters that are not immediately medical.

The examples reproduced here need no explanation, though they may need some thought. "The following persons will give me a satisfactory reference." "The following will support my application." "The experts listed below have promised to give a meaningful

recommendation for my appointment." "The following gents are my refs." "I have chosen these three distinguished colleagues to write me up." "Of the references named above please note that Professor ——— is the leading pathologist outside America." "Please do not contact reference No 2 unless I am being appointed as he is my present chief and I do not want him to know I am in for jobs." "These are my referees in order of merit." "As well as the three gentlemen named above, my father-in-law, my wife's father, Sir ———, the leading ———ologist and senior consultant at ——— Hospital, I am sure would speak for me off the record (he can be got in touch with by telephoning ——— any evening and at weekends, including all day Fridays). I have not asked him to be one of my referees in case this would be tactless."

Some candidates, in contrast to the simplicity and innocence of their colleagues who wrote the passages quoted above, are devious-seeming even to a degree that makes one question their judgment: they need not be quoted.

It is, perhaps, a complement of such brashness that so many candidates proceed to misspell their referees' names; give them the wrong initials; mistake their honours, degrees, and diplomas; attach them to the wrong institutions or change their specialty; and then, by making cardinal errors in giving their address, almost ensure that they cannot be communicated with. No wonder candidates make mistakes in the information they give about themselves. And I don't mean such mistakes as a recent classic, under the heading *Degrees and Other Qualifications*: "MRCP (UK), next examination."—WILL MACREDIE.