Tests on overseas doctors

TRAB. Isn't that something to do with seeing if immigrant doctors can speak English? Isn't the failure rate rather high? These popular half-truths both distort and underrate the task that the Temporary Registration Assessment Board has faced in principle since 1970 and tackled in practice six times since May 1975. The board was set up to test the clinical and English language competence of overseas doctors with qualifications for which the General Medical Council has no reciprocal recognition. Because the candidates' own countries will not allow examinations to be taken there, up to 3000 candidates a year may have to be tested in Britain, in perhaps twelve tests per year, taken at three centres. The General Medical Council turned for help to the three non-university licensing bodies, and each of them appointed two representatives to the new board; Dr T C Hunt was elected the chairman, and he co-opted expert advisers, including language experts from the University of Lancaster. The board agreed that clinical examinations were out of the question—and in any case this aspect was covered by the DHSS's clinical attachment scheme. Indeed, even with the new examination, a satisfactory testimonial from the supervising consultant remains a condition of employment in the NHS, quite apart from registration by the GMC.

As it has emerged, the test has four parts and occupies two days. Firstly, the 60 multiple-choice questions test medical knowledge. Secondly, recorded voices are used to test whether the candidate understands spoken English, including the meanings conveyed by intonation and stresses. Thirdly, there is a modified essay question—replying to a general practitioner, answering a patient, or giving instructions to the ward sister as part of an unfolding case history. Lastly there is a 20-minute viva, in which two examiners consider whether the candidate can sustain a sensible conversation with doctors, paramedical workers, and lay people on medical matters. So far there has been a reasonable correlation between a candidate's marks and a 50-60% pass in each part; though the overall pass rate for all the parts together has been around 30%.

Most of the problems of overseas doctors—their integration, training, and service contribution—have fallen on the staff of peripheral hospitals. Thus the 296 postgraduate medical centres and their clinical tutors are deeply concerned, and at the annual meeting of the National Association of Clinical Tutors at the Royal College of Physicians on 25 November the tutors cross-examined the President of the GMC, Sir John Richardson; the secretary for overseas affairs to the GMC, Mr Robert Beers; and the chairman of TRAB, Dr Hunt. The authorities regarded the language testing as satisfactory and even exciting—while, contrary to expectation and popular myth, they reported that it was seldom the sole cause of failure. On the other hand, the tutors regarded the clinical testing (done without the traditional tests of clinical skills) more sceptically, though the large number of examiners (120-130) needed were said to be experienced.

Later in the meeting the tutors had the unusual experience of trying to answer an MRCP paper, which must have made them realize some of the difficulties faced by the overseas doctors in taking this examination. One obvious question is how long can the high failure rates in the TRAB examination continue before clinical standards have to be lowered merely to staff the NHS? That question was asked by the tutors, but could not be answered by Sir John—though he was able to reassure the meeting that the DHSS had not made any difficulties about introducing the tests. Nor could he say how those doctors who failed managed until they could resist the

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1. The problem of hyperbaric rescue in the North Sea and its possible solutions. Society for Underwater Technology, 1 Birdcage Walk, London SW1H 9J
The ten day rule

There was some indignation when Which recently published a report on radiation safety and suggested that some hospitals were not following the standard safety procedures. Despite minor details deserving criticism, this report reflected the awareness of the public that x-rays cause damage. A long series of reports and reviews has discussed the risks and their reduction or elimination. The latest Code of Practice for the Protection of Persons against Ionising Radiations arising from Medical and Dental Use quite clearly states the responsibilities of a doctor referring a patient for radiological investigation. In all cases he must be sure that the possible benefit to the patient justifies the risk to that patient of radiation damage to organs, tissue, cells, gonads, or offspring. He must always give sufficient relevant clinical information to ensure that the radiographer and radiologist do the right examination in the best possible way and so gain the maximum of useful information with the minimum of exposure to radiation.

Tissues and organs are most susceptible to damage by radiation when they are most rapidly growing, and that occurs in utero. Every doctor asking for any radiological examination that will include the abdomen (including the pelvis and hips) of a woman of childbearing age (between 12 and 50) must include in his request the date of the last menstrual period. Whenever the examination may irradiate a patient’s uterus it should be arranged for a time when the patient could not be pregnant—that is, within ten days after the date of the last (or a future) menstrual period. That is the “ten day rule.” It may be ignored if the patient can affirm that she could not be pregnant, because there has been no recent sexual intercourse; because she has been on a contraceptive pill, or is fitted with an intrauterine contraceptive device proved effective over more than three months; or because she has been sterilised.

Exclusions from the ten day rule may include emergency admissions to accident and emergency departments and patients requiring urgent investigation in acute medical and surgical wards. Difficulties may arise with other hospital inpatients. The first responsibility for observation of the ten day rule lies with the referring doctor, who must indicate the date of the last menstrual period and whether urgency demands that the rule be waived. While the radiological department has a second responsibility to check omissions by the referring doctor, the clinic must avoid the criticism that will follow if the patient has to be turned away and given a further appointment by a reception clerk (or by a radiographer or radiologist) when she has already undressed and is perhaps on the x-ray table, perhaps prepared by fasting or purgation.

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Depression and curtailment of sleep

Insomnia is a common, distressing feature of depressive illness. It is therefore intriguing to find recent reports suggesting that deliberate awakenings can benefit the depressed patient.

The two kinds of sleep alternate about five times a night, and the phase of rapid eye movement (REM) or paradoxical sleep occupies about a quarter of the total. Many drugs reduce the proportion of sleep spent in this phase, but in clinical dosage the effect is most definite with the mood-enhancing drugs, amphetamine, imipramine, and the monoamine oxidase inhibitors. Phenelzine, in a dose of 60-75 mg daily, will bring about loss of the signs of REM sleep after 1-2 weeks, and the delay is the same as the delay to improving the mood, if this occurs at all. Conversely, reserpine often causes depression, and it is one of the rare drugs that increases REM sleep.

Vogel et al therefore argued that by awakenings at the right moments selective deprivation of REM sleep might have a therapeutic effect. They have recently reported that this is true for endogenous depression, though not for reactive depression. Seventeen patients with endogenous depression were awakened repeatedly as soon as they began REM sleep phases during a three-week period. Independent psychiatrists rated the mood of these patients to have become significantly more improved than that of 17 control patients awakened equally often from non-REM sleep. Though of theoretical interest, the findings do not, of course, offer a practical alternative to conventional treatments, since the all-night monitoring is a highly technical and expensive procedure.

This study was a careful one which recognised the many pitfalls in trying to establish that a new treatment really works. The same, unfortunately, cannot be said of claims in the last few years to the effect that if deprived patients are deprived of all sleep it helps recovery. Over the centuries, depressed, guilt-ridden patients have been subjected to treatments that others would consider punishments—flagellation, centrifugation, and cold douches—which should make us cautious before we add deliberate sleep deprivation to their troubles. Two writers from the Maudsley Hospital have reported that for most of 39 patients a single night of total sleep deprivation was quite acceptable as a treatment and that seven patients began a lasting improvement. In a more adequately designed study in the Netherlands ten depressed patients were treated in this way and were rated to be improved in mood during the day after an imposed sleepless night—during which, of course, they had received a lot of attention. Prompt relapse was usual, but overall the Dutch authors were evidently impressed by the temporary improvement.

As a research procedure, this approach may reasonably be taken further, but it should not be widely adopted at present. What is needed is a larger, carefully designed study, in which independent psychiatrists would use reliable tools for measuring depression and account would be taken both of the powerful effects of suggestion and of those natural processes that lead to recovery with the passage of time alone.

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