evidence that Indian candidates do worse than other groups. (See Table).

TABLE
Successes in Parts A and B of the Diploma of Psychiatry awarded by the Institute of Psychiatry

Country of Origin	*No*	*Passes 1st and 2nd attempt %*
Part A		
Africa (exclud. Sudan)	7	5 (71%)
Sudan	8	8 (100%)
Indian Sub-Continent	27	21 (78%)
Middle East	22	20 (91%)
Far East	4	3 (75%)
S America/Europe	6	5 (83%)
Part B		
Africa (exclud. Sudan)	5	3 (60%)
Sudan	9	7 (78%)
Indian Sub-Continent	19	12 (63%)
Middle East	23	17 (74%)
Far East	5	4 (80%)
S America	4	4 (100%)

Like the Membership, the majority of those who fail the Diploma (Part B) do so in more than one part of the examination.

Clearly, there are many reasons why candidates fail post-graduate examinations in this country and the College now provides an excellent system for providing individual feed-back for failure in the Membership; a service which we believe is unique among the Royal Colleges. We would also strongly support the recommendation of the Collegiate Trainees Committee that greater advantage is taken of this. However, based on this Institute's wide teaching experience with examination candidates from many different countries, we would like to make the following general observations concerning the reasons for failure that apply more specifically to doctors from abroad and which are not simply due to poor command of the English language.

First, some candidates seem unfamiliar with examination methods in this country. There are still a surprising number of candidates who are unable to deal with the common type of essay or viva question that requires discussion or application of knowledge rather than mere repetition of facts. Consequently, such candidates may have adequate 'book' knowledge, but fail for not having answered the question that has been set in the case of the essay or who are 'thrown' by the case vignette style of viva question.

Secondly, the clinical examination is still a great obstacle for many. Candidates often have the impression that something novel is required of them and that the examination is in some way very different to ward patient management with which they are familiar. Although by its very nature the examination setting is artificial, demonstration of the candidate's clinical competence to take charge of patients is the prime issue, and this must be demonstrated to the examiners. Frequently the problem is that trainees are not required to assess patients adequately in their 'ward round' presentations, and restrict themselves to factual presentations, leaving the thinking and planning to be done by senior colleagues. Training schemes need to foster the regular presentations of patients at case conferences on ward rounds, with the trainees being asked to formulate their assessment in the manner required under examination conditions. Although the overconfident candidate may fail to impress, one of the major difficulties for overseas candidates, in our view, is lack of confidence in the case assessment, and this can be compounded with increasing number of attempts at the examination.

The solution is for the candidate to spend less time reading books and more time practising examination technique with colleagues (preferably senior). As well as practising essays, MCQs and 'mock' vivas (with emphasis on the 'case vignette' style of question) we advise that candidates should clerk at least 10 common psychiatric cases under examination conditions by allowing themselves only one hour to clerk and prepare an assessment on a patient not known by them. The case should then be presented to a colleague in the correct examination format in 30 minutes (i.e. assessment including salient features of the history, mental state findings, differential diagnosis, possible aetiological factors, followed by management and prognosis). Attending a course in examination technique may help, but cannot completely replace the need for individual practice and thorough familiarity with the examination format.

Finally, we would like to emphasise that the above comments are our own and that we are not representing the views of either the Institute of Psychiatry or the Royal College of Psychiatrists. However, we hope that they may be of help to those who are sitting psychiatric examinations in this country.

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DEAR SIRS

As a psychiatrist involved with a Postgraduate Teaching Programme designed to help junior doctors with their MRCPsych examination I am aware that of the total number of doctors who sit their examination each year the pass rate is considerably higher among the British doctors than among those for whom English is a second language.

One of the reasons for this, in my opinion, is that in the multiple choice questions certain words are used which are difficult to evaluate by the foreign doctors e.g. commonly, frequently, significantly, occasionally. It would be helpful to the foreign candidates if a rough guide as to what is expected in percentages was to be given for these and similar

terms in the multiple choice questions. It think that if these and other equivocal words are clarified by the Examination Board one would find a narrowing in the gap between the British doctors' and the foreign postgraduate doctors' examination results.

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Psychiatrists and political movements

DEAR SIRS

I would like to sound a note of caution in relation to identifying psychiatrists with political movements. I was delighted to note that Dr Maclay (Psychiatry and the Peace Movement *Bulletin*, April 1986, **10**, 83–84) and Professor Clare, when inviting psychiatrists to support the Nuclear Freeze Organisation, have not suggested a psychiatric parallel to International Physicians for Prevention of Nuclear War. As an early and enthusiastic member of the Doctors and Overpopulation Group, and supporter of nuclear freeze, I believe it is important to distinguish causes where doctors and psychiatrists have a special responsibility (e.g. the provision of contraception, and the use of psychiatry to detain political dissidents) and ones where our views are no more valid and relevant as others outside our profession. I expect most psychiatrists would be actively involved in political movements as an expression of their concern for the community as a whole.

Were one to link a political view with a group of psychiatrists the object would be to promote that cause by increasing publicity under the impression that the views of psychiatrists should be adopted by others. Our patients are by their very nature disordered in their thinking and may have views diametrically opposed to ourselves. Such patients should not come to psychiatrists reinforced in the belief that psychiatrists have attitudes and beliefs antithetical to their own. Thus the very effectiveness of such a link would reduce the clinical potential of psychiatric treatment, quite apart from increasing the barrier against psychiatric consultation.

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Approval under Section 12(2) of the Mental Health Act 1983

DEAR SIRS

Over the past few years I have come across approved doctors of some seniority who did not show the degree of grasp of the most essential provisions of the Mental Health Act that one would have expected of them.

I would therefore like to suggest that in order for the approval of Psychiatrists under Section 12(2) to have the most meaning, not only should applicants for approval be Members of the College (which I understand is already the case), but that they should also be required to show their understanding of the Mental Health Act by way of an oral test set up by the Regional Health Authority concerned. This way we would know that those who are approved actually do have experience in the diagnosis and treatment of mental disorders and are also confident in interpreting and applying the various provisions of the Mental Health Act.

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Consultants and administrators

DEAR SIRS

Sitting in a recent senior medical staff committee, listening to an animated and rather chaotic discussion of the impact of recent ward closure and cost cutting exercises, I was struck by the similarity to a recent marital situation which I have been treating.

In this case the consultants represent the injured party (the woman). They are hot-headed, temperamental, prone to hyperbole and exaggeration, while feeling ignored and helpless. They feel their patients (the children) are suffering at the hands of the stingy budget-dominated administrators whose callous disregard for patients wellbeing is hidden behind an inscrutable mask of calm control (the husband).

As in the marital situation, the administrators regard the consultants as irresponsible, over-emotional, chaotic, lacking in judgement, and unable to manage. They perceive themselves as balanced, rational and in command. They harbour fears of wildly extravagant behaviour were the consultants ever to have free rein with the money.

Maritally this dynamic is common. This is because it receives social sanction, conforming as it does to stereotyped views of sex role behaviour. In the relationship the woman is defined as a child and the man her controlling father. She loses her sense of responsibility and control over her own destiny in exchange for care and protection provided by her husband. Unfortunately, the less benign aspects of the relationship involve a progressive loss of self-respect, demoralisation and depression. Because of the interdependence which develops there is an apportionment of qualities between the couple with each needing the other to contain unwanted aspects of themselves. This is referred to as projective identification.

With the passage of time each person's behaviour becomes exaggerated like a caricature. The woman is over-emotional as she carries her husband's unwanted passions which allow him to stay calm and in control. The man is rocklike and unfeeling as a result. Outbursts by the woman