Which brings me to the Chief Examiner's response to the letter (*Psychiatric Bulletin*, March 1994, **18**, 175). However necessary the exam, as a threshold and a stimulus, it can also impede one's training. As a registrar one usually rotates through six month slots of psychiatric subspecialties. When the candidate sits the examination in one such period, with time off for a revision course and independent study leave, it is unlikely that he or she will have the energy or motivation to read up about the subspecialty he or she is attached to. With a pass rate of 195 out of 405 candidates this is likely to happen more than once.

Maybe registrar training could be organised like GP training; for example, a rotation of two years through different attachments like general psychiatry, child and family therapy, old age psychiatry, community psychiatry, learning disability and forensic psychiatry. Each could be examined in their own right, and date. This would enable registrars to study the subject they are working in and leave enough time for a three year higher psychiatric training and thus comply with 'specialist-training'.

R. STOCKING KORZEN, *Hillview Lodge, Royal United Hospital, Combe Park, Bath BA1 3NG*

Sir: I read with interest the comments by Akintunde Akinhunmi pertaining to the MRCPsych Part II examination (*Psychiatric Bulletin*, March 1994, **18**, 175).

The College rightly attaches the utmost importance to the clinical component of both examinations (Part I and Part II) leading to Membership. Candidates cannot pass unless the clinical is successfully negotiated. Perhaps it would therefore be more appropriate to exclude from the written papers candidates who fail the clinical. In its current form I believe candidates should not be excluded from the clinicals if they have already failed the written papers; in any case, I doubt if there would be adequate time to mark the written papers before the clinicals in the case of Part II. A further consideration are the criteria which need to be met for success in the examination. Currently a failure in the written papers does not mean automatic failure overall, providing the candidate passes the clinical; I believe it should stay that way.

I can understand the anxieties about the cost of the examination. The College has a duty to minimise these, while maintaining standards. Perhaps the activities of the examinations department could be audited and the results published annually in the *Bulletin*?

Performance in the clinical examination might actually be made worse by knowledge of success in the written papers (leading to heightened anxiety)!

Finally, I do not think it would be fair on candidates who are borderline if those who have clearly passed know their results first. The only way to speed up the processing of results would be to employ more staff – which would increase costs. I feel strongly that candidates should *not* be informed immediately if successful. There should be opportunity for reflection by the Examination Sub-Committee. For those candidates who have failed the examination, feedback on performance should be prioritised; some candidates have been receiving their feedback only days or weeks before their next attempt. This is clearly unsatisfactory.

STEPHEN M. JONES, *Norwich Psychiatry Rotation, West Norwich Hospital, Norwich NR2 3TU*

Sir: I note the points that Dr Jones makes and will make sure that these, together with other points made regarding the examination, are brought to the attention of the committee reviewing the examination.

SHEILA MANN, *Chief Examiner, The Royal College of Psychiatrists*

Mental Health Act (MHA) as an exam topic for the MRCPsych?

Sir: The issue of the need for training in the MHA arose from the recent Mental Health Act (MHA) Conference in London. Indeed, section 12 approval of psychiatrists does not include formal testing in the MHA. How better to encourage trainees to learn the MHA than to make it an examinable topic? The difficulty, as I understand, lies in the difference between Scottish, Irish, English/Welsh laws, and that there are candidates from Hong Kong.

I put the issue to my colleagues in the St George's Hospital Psychiatric Rotations (South West Thames Region). Fifty questionnaires were distributed to senior house officers and registrars and 40 responded; 11 had no Part I, 26 had Part I and 3 had Part II. Thirty-four were keen to have formal teaching in the MHA. Twenty-six (65%) rated their knowledge of the MHA as fair, 11 as 'poor' and one said he/she knew nothing! The most common source of knowledge was 'on-the-job' (93%) but 60% also who read up on the MHA. Among other sources of knowledge, one trainee included 'social worker', and another said 'lawyer'!

Twenty-eight (70%) wanted the MHA to be an examinable topic in the MRCPsych, while only nine said no, and three said they did not know. It was clear that the majority were recognising the importance of the MHA although, in this group of 28 trainees, six (21%) rated their knowledge of the MHA as poor.

It is of concern that among the 12 who rated their knowledge as poor or nil, six had had more than two years in psychiatric training. Fortunately, St George's Training Scheme has a Mental Health Act Day in the regional Part II course. The Day is also open to GPs. Participants are taken through the MHA and discuss applying the MHA in case vignettes.

Psychiatrists will have to lead the way in knowledge and application of the MHA. Indeed, one respondent to the survey wrote that GPs often called the duty doctor to ask how to 'section' patients!

JEYABALA BALAKRISHNA, *Atkinson Morley's Hospital Wimbledon, London SW20*

Sir: I was concerned to read Dr Balakrishna's letter and note the poor level of knowledge about the Mental Health Act described.

No doubt all those concerned in the training of junior psychiatrists will note this. I was also disappointed, but not surprised, to be reminded that trainees perceive the presence of a topic in an examination to be a particular spur to the acquisition of knowledge. There are many very important areas in psychiatry which cannot be examined formally in the MRCPsych examinations, knowledge of which is vital for practising psychiatrists. At the present time it has not proved practicable in written examinations to examine fairly the minutiae of four different Mental Health Acts, although the principles behind Mental Health legislation, as trainees will be aware, are examined. Any aspect of mental health legislation is likely to be a topic in clinical and oral examinations provided examiner and examined are acquainted with the same jurisdiction.

Section 12 approval, in England and Wales, is of course granted by regional health authorities and I know that discussions are taking place as to how best to ensure that those given section 12 approval have an adequate knowledge of the Mental Health Act. I am sure that Dr Balakrishna's letter will remind all psychiatrists of the importance of ensuring that they personally acquire adequate knowledge of this subject.

SHEILA MANN, *Chief Examiner, Royal College of Psychiatrists*

Sexist language

Sir: There is no dearth of sexist words that one comes across in daily life so there are a lot of sexist issues one can raise. People may even object to being referred to as 'him' or 'her' because it is discriminatory or against their gender identity. A news item (*Oman Observer*, 31 March 1994), mentions a Papua-New Guinea island where the language does not recognise gender differences and there are no terms like 'he' or 'she'. It has taken the lead from the civilised world. The problem may persist until a whole new non-sexist English evolves. After that, all sexist labels like Sir, Madam, Queen, King, ladies' club, stag party, women's lib, motherland etc., would become obsolete and replaced. Even a *Men*tal state Examination, *man*-made, penis envy and patient *man*agement would become archaic!

I could not think of a really suitable alternative for 'Sir' to start this correspondence – and it seems that neither Dr Fiona Caldicott nor Dr Joanna MacDonald could think of it (*Psychiatric Bulletin*, March 1994, **18,** 175). Could someone suggest a single non-sexist word that can be used to start such correspondence. The traditional 'Sir' may be inappropriate in more ways than one – the editor may neither be a man nor have a knighthood.

Maybe *MEN*SA will come up with the equation, Mrs:Ms therefore Sir:Si? Until then, according to Dr Caldicott's quotation, let *Sense and Sensibility* reign.

YOUSUF KAMAL MIRZA, *Ibn Sina Hospital, PO Box 3, Al-Amerat, Muscat-119, Oman*

Sir: The question raised by Dr Joanna MacDonald in the *Psychiatric Bulletin*, March 1994, **18,** 175 is of considerable moment and many of us will be unable to sleep until it is resolved. The appearance of the word 'man' as the component of a longer word is a challenge, a provocation or, a cause of concern and disappointment to some people, and as members of a caring, indeed sharing, profession, we should not pass by on the other side.

Dr MacDonald suggests the word 'workforce', and we must be grateful for a possible way out of this semantic and political dilemma. However, I am troubled by the word 'force', with its connotations of power and militarism and hint of phallocentrism. Our own police have long dropped the epithet 'police force' in favour of 'police service', and we should be thankful for that. Further, the word workforce conveys an image of the labouring classes in serried ranks and this succeeds, unfortunately, in being collectivist and élitist at the same time. I think we should leave 'force' out of it.

I don't have a suggestion to make except to hope that the debate continues. However, I do want to express my profound admiration for our President's reply, which is a masterpiece of statesmanship and literary allusion in keeping with the motto of the College.

DEREK STEINBERG, *Ticehurst House Hospital, Ticehurst, East Sussex TN5 7HU*