concerned to promote research by trainees in psychiatry. There is considerable awareness among trainees themselves of the need to become involved in research and to publish in order to progress in their careers (Junaid & Staines, 1990). When asked, trainees claim to be well motivated to carry out research (Royal College of Psychiatrists, 1991).

Trainees consistently complain of inadequate training, advice and support with regard to research. The 1991 report of the Collegiate Trainees' Committee stated that 40.5% of trainees were unaware of any available research training, locally or nationally. Only 24% felt that their research training was 'adequate', and among trainees working in district general hospitals, this figure dropped to 14%. Amazingly, 16.2% of trainees reported active discouragement in producing research.

Surely the College should now advocate systematic research training and supervision for all trainees in psychiatry. The recent initiative from the Research Committee of the College in proposing the creation of a network of research tutors is a welcome first step (Freeman, 1992). The tutors will have a general responsibility for promoting research among trainees, and for giving guidance and advice. This may be done personally, or by a nominated supervisor. They will also keep a register of trainee research and a data bank of important research methods, papers, books and questionnaires.

In addition the College should advance a set of guidelines in order to standardise training in research.

(a) Each training scheme should have a nominated tutor responsible for coordinating and supervising trainee research, and promoting a research programme.
(b) Each trainee should have his/her progress reviewed at regular (at least six monthly) intervals.
(c) Each trainee should have time set aside in the timetable for research and research training.
(d) Each training scheme should provide an organised course of teaching covering literature searching, ethics, protocol design, data collection and the statistical and computer analysis of data.
(e) The College's Central Approval Panel should be asked to consider the level of provision of teaching and supervision of research when asked to approve a training scheme in psychiatry.

I submit that the College should move to establish minimum standards for the teaching, supervision and promotion of research by trainees, and that advocating the above guidelines would be a good beginning.

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## *Reply*

DEAR SIRS

I support all the points that Dr Sullivan has made and would like to reassure him that all his suggestions are being taken further by the Research Committee and its Research Tutors Initiative. I don't think that a formal review of progress every six months would really solve the problem of supervision. Research supervision needs to be flexible. It may need to be quite frequent at the planning and writing-up stages of a project but quite widely spaced at other times. I think it is important that we don't put further hurdles in a trainee's career. Research is important and every trainee should have teaching in research methods and be able to critically appraise research projects and published papers, but actually carrying out a research project is not for everyone.

From the evidence of our Research Methods Courses there is no doubt that there is plenty of enthusiasm for research among trainees and many good ideas but that trainees still find great difficulty in finding good quality supervision. Our hope is that in the future the Research Committee can concentrate its efforts on helping to train and support the research trainers rather than offering the training directly. It is not going to be an easy task. It is likely that post Calman psychiatric training will be considerably shorter and more intense, perhaps leaving even less time for research. May of those who would be best suited to be research tutors are busily involved in their own research projects as well as doing full-time clinical jobs and therefore have little time left for supervision.

C. P. FREEMAN
*Chairman*
*Research Committee*

## *Royal College ECT video*

DEAR SIRS

I was pleased to see this excellent introduction to ECT, but would comment on areas which may prove controversial.

The guidelines on room sizes could have been more prescriptive. The anaesthetic and nursing guidelines will make life easier for service planners, as well as

those contracting with acute services, while moving towards uniformity across the UK.

A training video should confine itself to established facts or clearly identify 'grey' areas. To imply that propofol should not (ever) be used in ECT is wrong. More accurate is that propofol reduces seizure duration and that the clinical consequences of this is unknown. Hypertensive patients for example *might* benefit from propofol?

The video demonstrated electrode positioning at a point 2 cm perpendicular to the mid point between the angle of the eye and the external auditory meatus. I suspect the "two centimetres" quoted should have been two inches as four centimetres is nearer the existing recommendations.

The technique of 'hyperoxygenation' referred to as a fit provocation technique may act by inducing *hypoxia* – or at least that is one considered mechanism to explain the EEG response to hyperventilation through cerebral vasoconstriction. It is stated as being "harmless" in the video, but many EEG departments consider it potentially hazardous in the elderly or those with vascular insufficiency.

The emphasis on stated consultant sessional input is good, as is the idea that fewer junior doctors at a time ought be on an ECT rota. But surely it is not so inappropriate for GP trainees to participate in ECT administration?

While fit threshold is higher in men, and higher in older people as stated, it is also higher with dehydration (relevant when patients are not drinking). Fit threshold is stated as being higher for bilateral ECT, and yet higher energy levels are often needed for unilateral ECT as (presumably) more energy is lost through short circuiting.

The TEST facility on the ECTRON series 5, according to a communication from ECTRON, is a guide only. They say that failure of the test light to flash before administration is *not* a cause for concern because of some patients having a very high static impedance, but much lower dynamic impedance.

I am pleased to see the College taking a lead in modern forms of communication. The finished product, with audience participation is a good use of 55 minutes. As the video says however, it must supplement hands on training and the contents of the new handbook, and not "stand alone".

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## *Reply*

DEAR SIRS

We were aware that in producing a 55-minute video which includes quite a lot of technical detail there would be some points which caused debate. Several of the points that Dr Littlejohns raises will be addressed in the accompanying teaching manual. Unfortunately, this has been delayed because of an evaporation of secretarial support at the College. There clearly is one mistake. The 2 cms that Dr Littlejohns referred to should be 2 inches or its metric equivalent. This was a mistake that I made in the original filming. We did a subsequent take with the correct distance inserted but it is clear that the incorrect version has been edited into the final tape. We will amend this in subsequent versions.

C. P. FREEMAN
*Chairman*
*Special Committee on ECT*

## *The responsibility for the care of young brain-damaged people*

DEAR SIRS

I have never succeeded in getting a reliable answer to "*Who, precisely, is responsible for the medical care of people in their 40s and 50s with cranio-cerebral pathology expressed as organic mental disorders?*"

I have seen several of these patients passed, most distressingly for patients and carers alike, between general psychiatrists and old age psychiatrists, and felt troubled at the lack of definite assignment of their care to a specific branch of psychiatry. While acknowledging the difficulty of the undertaking, I would request help to resolve the question of which psychiatrists are responsible for the young brain-damaged, whatever the aetiology.

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## *Reply*

DEAR SIRS

Old age services do not routinely accept a responsibility for patients of all ages who are suffering from acquired brain damage. It is increasingly common for patients suffering from dementia in the presenium to be managed by local old age services; this is a matter of local agreement and for agreement over individual cases. There is widespread support for the idea of Sub Regional Units/Services for patients and families where dementia presents in this age group.

A working group chaired by Professor McClelland considered this issue and the wider context of services for the younger patients with acquired, often traumatic, brain damage and published their recommendations in the *Psychiatric Bulletin* (1991, **15**, 513–518).

DAVID JOLLY
*Chairman*
*Old Age Section*