I can sympathise with Dr Double's point about protecting less experienced trainees from inappropriate service responsibilities and trust that we will be even better at doing so when postgraduate medical training is more protected within the NHS, and the service staffed with appropriately trained people in order that this can occur, as *Achieving a Balance* and 'Calman' require.

Is recruitment to psychiatry falling, or are we being affected by the devastating drop in recruitment to general practice?

Finally, I find Dr Double's labelling of me as "conservative" ironic.

F. CALDICOTT, *President, Royal College of Psychiatrists*

Sir: It is unfortunate that the debate about improving psychiatric training in response to Calman has cencentrated on where exactly the split between basic and higher specialist training should occur and when exactly to award the CCST. This had obscured discussion about how to improve the quality of psychiatric training, which is far more important than what we call trainees for how long. Debate at the latest CTC meeting attempted to address issues such as content of training; setting training goals; educational contracts; methods of assessment; feedback and progress reviews; the role of research; flexible training. Calman's proposals for structured training were intended to address much more than just the structure of the training grades – a fact we would all do well to remember.

STEFFAN DAVIES, *Chairman, Collegiate Trainees Committee, Royal College of Psychiatrists*

Sir: Evans & Johnson (*Psychiatric Bulletin*, July 1994, **18**, 405–407) cite two possible models for the delivery of medical care: an elite body of consultants with a small group of trainees (most of the clinical work being undertaken by non-consultant career grades), and a large body of consultants with increased clinical care. The Calman Report seems to aim towards the second model. However, while its recommendations have been accepted by the government, no extra funding has been set aside to implement them. This, coupled with the Health Minister's intention to ease restrictions on numbers of SHOs and staff grade doctors, suggests that we are in reality moving towards the first model.

The paper reports that 69% of the senior registrars were not in favour of a new NHS sub-consultant grade. Presumably they see themselves being promoted to the first model's "elite body of consultants", rather than filling the non-consultant career grades. However, in all probability a significant proportion will become caught in the post-CCST (Certificate of Completion of Specialist Training) gap, exposed to the potential for exploitation as cheap labour by NHS trusts.

Rather than resign ourselves to the inevitability of a sub-consultant grade introduced through the back door, we might do better to embrace the opportunity to develop a new specialist grade. This could meet many of the needs created by the complex changes occurring within health care. A period of independent clinical practice post-membership would meet some of the increased service needs created by reducing juniors' hours while addressing the expectation that an increasing proportion of patients will be treated by trained specialists. If such posts allowed progression to consultant status they would not be seen as 'dead end' jobs but as a period where further experience and skills could be developed. This period could have fewer of the management and non-clinical responsibilities of consultants, and be of variable length to give greater security while allowing the necessary flexibility to meet the needs of individuals. Surely it is better to negotiate suitable terms and conditions for a specialist post now, rather than let ourselves be shunted into an inferior sub-consultant post by default.

DAVID ROBERTSON, *Department of Psychiatry, University of Leicester, Leicester General Hospital, Leicester LE5 4PW*

Care programme approach

Sir: Nigel Fisher's (*Psychiatric Bulletin*, August 1994, **18**, 453–456) valuable editorial on community care may have been too charitable about the confusion of the political and clinical in policy. The imposition of the care programme approach (CPA) without a clear understanding of its impact has been wasteful for mental health services. I think trusts and districts are likely to remain confused despite the recent guidance on discharge and continuing care.

The essential problem has been in deciding to whom the CPA applies. There are also questions about the value of bureaucratising the care planning process. I am not convinced the Department of Health (DH) has fully considered these issues. The DH seems to have believed that it has exercised its responsibility by merely requiring the implementation of the CPA. Mental health services have not been blameless in this respect as they have not been very forthcoming in reporting difficulties in implementing the approach.