nursing staff, are proficient at CPR. Any planning of training courses must involve the staff who are in most contact with the patient and this is often the nurses. However proficient a doctor is at CPR it is useless if the patient is not oxygenated effectively until he or she arrives.

D.I. WILLIAMS, *East Glamorgan Hospital, Church Village, Pontypridd, Mid Glamorgan*

Psychiatric emergencies

Sir: A working party of the Collegiate Trainees Committee (*Psychiatric Bulletin*, June 1994, **18**, 357–359) drew attention to the management of violence as one of a number of areas of psychiatric training in need of improvement. Others included community, liaison and forensic specialities. Emergency psychiatry may represent the richest source of experience in all these areas and there currently exists an opportunity to change the profile of on-call activities dramatically: instead of having to be resident in a psychiatric hospital, the SHO/registrar can now work in the community while covering the general wards and casualty.

This should not disadvantage the psychiatric wards of a trust. In a recent survey of the out of hours activities of resident junior medical staff at the 235 (mostly acute) bedded Hollymoor Hospital, nearly a third of calls to the wards were for routine work. Of the problems that arose out of hours, 30% did not require a visit to the wards; of those that did, 43% involved some form of administrative duty that could have waited. The total time that a psychiatrist spent on clear-cut emergencies was four hours and 40 minutes. Roughly two thirds of this time was spent dealing with medical or surgical emergencies.

An on-site psychiatrist has a limited role. Community and liaison activities would broaden the experience of being on call and partly rectify the reported deficiencies. Close supervision of an inexperienced but mobile SHO/registrar by a senior would provide unique opportunities for training. In the early weeks, the supervisor could be 'shadowed' by the trainee, independence developing once a suitable amount of experience had been accumulated, perhaps being documented in a logbook and overseen by the clinical tutor.

NEIL DEUCHAR, *Registrar, The Queen Elizabeth Psychiatric Hospital, Edgbaston, Birmingham, B15 2QZ and* KEVIN LANE, *Medical Audit Assistant for Psychiatry, Solihull District Health Authority, Hollymoor Hospital, Birmingham, B31 5EX*

Fund-holding general practice and old age psychiatry

Sir: I read Fear & Cattell's paper on fund-holding general practices and old age psychiatry with considerable interest. (*Psychiatric Bulletin*, May 1994, **18**, 263–265). We are, of course, all heading down this road to either heaven or perdition. Some aspects are not commented upon by the authors.

First, the massive increase in domiciliary consultations from non-fund-holders between April 1991/92 and April 1992/93, yet out-patient referrals for non-fund-holders remain the same as do referrals to community teams by general practitioners, while community team referrals by other agencies fall. However, for fund-holders the opposite is the case. Referrals by domiciliary consultation and community team referrals by GPs both fall but community team referrals by other agencies interestingly increase by ten.

Are GPs trying to minimise their costs of psychogeriatric patients by reducing direct referrals to community team referrals or domiciliary consultations? Other agencies are increasing their referral rates for fund-holder patients. This would support the supposition that appropriate referrals by GPs to specialist services are increasing other (by the back door) referrals to the psychogeriatric team. Certainly, there is longstanding evidence that if psychogeriatric patients, particularly those with dementia, are not provided with services specifically to meet their requirements then they enter the healthcare system by any loophole available to medical and orthopaedic wards, inappropriate and untimely placements in nursing homes, etc.

Psychogeriatrics as a speciality came into being to prevent this misuse of expensive alternative NHS resources by inappropriate placements.

Maybe we are travelling 'back to the future'.

R. M. PHILPOTT, *EMI Directorate, Sir Douglas Crawford Unit, Mossley Hill Hospital, Liverpool L18 8BU*

Career guidance for psychiatric trainees

Sir: We agree with Kehoe *et al* (*Psychiatric Bulletin*, March 1994, **18**, 161–163) that there are deficiencies both nationally and locally in career guidance for psychiatric trainees. A recent study surveyed 73 career psychiatric trainees at SHO and registrar level in Merseyside and had a response rate of 59% with 43 questionnaires being returned. It showed that only 43% had received advice about how to structure their career. This included advice on psychotherapy

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training (48%); job interview techniques (28%); subspecialties (22%); preparation of a CV (18%); regional differences on training (10%). This advice was mainly provided by consultants (85%); clinical tutors (58%); peers (21%); SRs (12%).

Exam related advice was given prior to Part I to 87% of trainees and to 78% before Part II. Feedback following exams was less frequently received: after Part I by 36% and Part II by 62%.

Asked about advice received on further academic opportunities, 47% had been informed about training courses; 52% about practical research issues and 40% about research supervision; 34% about the local MPsych Med degree and 11% about higher degrees. It was an interesting finding that this was nearly exclusively provided by supervising consultants and only by clinical tutors in 4%; 44% of trainees expressed concern about confidentiality if they were to discuss personal problems.

As supervising consultants still appear to provide the main bulk of career advice, we feel they need to be aware of the breadth of topics that need to be addressed in supervision and of the requirements of psychiatric training. On the basis of our findings, we would recommend the allocation of personal tutors (mentors) for long-term advice during general training in order to provide consistency and continuity in both personal and professional guidance while ensuring confidentiality and impartiality.

BRIGITTA BENDE, *Rathbone Hospital, Liverpool, L13 4AW* and RICHARD HOPKINS, *Ashworth Hospital, Parkborn, Maghull, Liverpool, L31*

Recommended: The Royal College of Psychiatrists' 'Directory of Specialised Psychiatric Facilities'

Sir: If you have wondered whether a specific facility was available, and, if so, where it was located, only to find that this information was often a matter of someone saying "I understand that there is an affective disorders unit at such and such a hospital . . .", I hope you will join me in requesting our College to take steps to compile a *Directory of Specialised Psychiatric Facilities* to document all that is available in the United Kingdom and the Republic of Ireland.

Such a directory should cover the National Health Service as well as the private sector, and include the following, with adequate information on referral criteria, costs and (in the case of NHS facilities) whether these are catchment area bound, regional or supra-regional services: adolescent units; affective disorders units; aftercare hostels; alcohol-related disorders treatment and rehabilitation units; behavioural disorders units; drug treatment units; eating disorders units; employment rehabilitation units; facilities for mentally ill without hearing or speech; facilities for young brain-damaged people; in-patient psychotherapy units; in-patient mental impairment facilities; mother and baby units; neuropsychiatric assessment and treatment units; obsessional disorders units; phobic disorders units; active rehabilitation hostels; therapeutic communities; psycho-surgical units; facilities specifically for people of a particular language, culture or nationality.

It would also be helpful if private psychiatric hospitals could be invited to include in the directory a list of their staff and visiting consultants, and the areas of psychiatric care in which they are particularly strong.

I believe that such a *Directory of Specialised Psychiatric Facilities* will prove to be immensely popular, and could be a useful source of income for our College.

IKECHUKWU O. AZUONYE, *Forest Healthcare NHS Trust, Claybury Hospital, Woodford Bridge, Essex IG8 8BY*

Image analysis

Sir: Dr R.M. Bilder and colleagues (1994) have suggested that a complex expert (computer) system for MRI image analysis is inferior to the combined expertise of a team of trained (human) experts. There may be an explanation for this which transcends the anthropomorphic perspective.

The number of possible pathways in any computer program rises as a fractional proportion of the factorial of the number of branch points in the program. The general relationship is given by

$$N=fB!$$

where N, the maximum number of pathways is determined by the factorial of B, the number of branches. Some pathways, being mutually exclusive, are not permitted, thus giving rise to the fractional multiplier f.

Factorial functions rise astonishingly rapidly. For example, an imaginary 'expert' system with only ten branch points would give rise to 3,628,800 possible pathways if all were permitted. For the expert systems of today we are looking at programs with the possibility of over a 1000 branch points. The factorial for this number of branch points is nearly incalculable, and even if many of the pathways are mutually exclusive (if f, say, is only 0.0000001, i.e. only one in a million pathways is permissible) the number of permissible pathways is still huge.

The consequence of this is well recognised outside of psychiatry. The number of pathways

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