the structured training programme published by the College and the Joint Committee on Higher Psychiatric Training (JCHPT) is of three years in length. This is in contrast to the current situation where the JCHPT states that for each psychiatric speciality higher training is "at least three years in duration, and desirably four years".

Drs Cervilla and Warner refer to "the minimum of two years in a chosen speciality". This relates to the fact that in most psychiatric specialities a year's higher training in one of the other specialities is a recognised part of the programme, e.g. in general psychiatry for those specialising in old age psychiatry.

While agreeing that dual accreditation is highly desirable, and that the approach to the provision of psychiatric services by Trusts is liable to change, I do not know what the evidence is for the statement "clinicians in specialities may be required to undertake work in general adult psychiatry in the future".

It is not the case that "participation in 'on-call' rotas which cover adult psychiatry will also require accreditation as a general psychiatrist". I have clarified this issue with the officers and officials of the GMC and have been assured that the specialist list will be indicative in the sense that it will show the completed specialist training undertaken by an individual, but not that he or she is not competent to provide cover in related areas of medical practice.

The length of training for the psychiatric specialities other than general psychiatry has not been increased as I have indicated above. A specialist in the psychiatry of old age will be eligible to apply for consultant posts in that speciality upon receipt of a CCST in it after three years' higher training, just as they can at the moment.

In relation to the point that is made about doctors who wish to practise elsewhere in the European Union (EU) than in the UK, it is true that many EU countries do not recognise some of the specialities of psychiatry which are recognised in the UK. It is important to point out that a CCST in a speciality is not an absolute requirement for approval to practise in another EU country but more importantly each sovereign state of the EU is able under European law to decide which specialities of medicine (and therefore of psychiatry) it wishes to train doctors in for practice at home.

It is not accurate to say that "the Calman exercise took place in order to bring the length of specialist training in the UK into line with the rest of Europe". Dr Calman's initiative in relation to specialist postgraduate medical training related to the threat of infraction proceedings against the UK government as some Colleges were issuing certificates of 'completed' specialist training for the EU after a shorter period of higher training than 'accreditation' required for eligibility for consultant practice in the UK. Again it is important to state that the length of specialist training stipulated for practice in an individual country is a matter for that sovereign state.

It is gratifying that in discussions on the European Board of Psychiatry (of which I am the Secretary), which is accountable to the Mono-specialist Section for Psychiatry of the UEMS, most other European countries are striving to lengthen their training to bring it in line with the UK and Ireland.

It is true that some European countries currently award CCSTs or their equivalent after four to five years' postgraduate training. Such individuals will be eligible for consultant posts in the UK. However, it is important to point out that there is a difference between eligibility and appointability as employers will wish to be assured that applicants are fluent in English and have appropriate expertise and competence, e.g. in legal aspects of psychiatric practice such as Section 12 Approval to undertake the responsibilities of a particular post.

I trust that my counter-arguments to Drs Cervilla and Warner's letter are clear. The administrative officer of the College responsible for our implementation of Dr Calman's recommendations is Suzanna Gray and I hope that any Member, Fellow or inceptor of the College who is not clear about the arrangements that are being put in place will contact her so that accurate information about particular situations can be promulgated.

FIONA CALDICOTT
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Psychiatrists' complementary skills

Sir: Dr S. Timimi questions "whether research among trainees is desirable" (*Psychiatric Bulletin*, November 1995, **19**, 707), but then suggests that he has an unusual understanding of scientific principles and of 'psychiatry's scientific framework'.

Dr Timimi believes that "psychiatry's scientific framework and categorical validity rests on an idea of common consensus, as opposed to discretely measurable phenomena". He appears to be confusing our (currently) syndromal systems of classification with the evidence upon which practice in psychiatry is based. The latter has become far more objective over recent years, with its emphasis on rigorous research methodology and more objective measuring tools, with stated validity and reliability. He suggests that more importance should be given to "developing theoretical understandings that allow the trainee to question and criticise the scientific assumptions made by researchers". The whole point of scientific research is that assumptions are

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avoided as far as possible. Indeed, the theoretical and "subjective aspects of psychiatry such as . . . a psychotherapeutic qualification, and perhaps exposure to personal therapy", which he is advocating in place of research experience, are precisely the areas which tend to be characterised by unprovable assumptions and lack of evidence of validity and usefulness.

He calls for trainees to be encouraged to develop these 'theoretical understandings' rather than gain research experience. This is at a time when psychiatry across the Atlantic is undergoing a profound reassessment of psychoanalysis and its place within psychiatric training (Clare, 1995), and the need for 'evidence based medicine' is being increasingly recognised.

I would agree that it is important not to become "academically knowledgeable at the expense of being technically and therapeutically competent", but these are not mutually exclusive. Academic knowledge and therapeutic competence are complementary. Clinical training in psychiatry is of paramount importance, including psychotherapeutic knowledge and skills, but the several and varied benefits of carrying out research projects as a trainee should not be overlooked (Trigwell, 1993).

Many trainees experience difficulties in carrying out research but problems are also encountered while gaining the type of theoretical knowledge advocated by Dr Timimi (Clare, 1995; Trigwell *et al*, 1995). His letter is a comment upon an earlier paper which put forward a strategy to improve standards of education and supervision for research by trainees (Owens *et al*, 1995). A similar initiative which improves education in the theoretical areas mentioned by Dr Timimi would be most welcome.

CLARE, A. W. (1995) Commentary on 'Training in psychodynamic psychotherapy: the trainee's perspective'. *Irish Journal of Psychological Medicine*, **12**, 59–60.

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TRIGWELL, P. J. (1993) Too much doom and gloom. *Psychiatric Bulletin*, **17**, 558.

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Sir: I was glad to read Dr Trigwell's letter which defends the role and importance of research in the training of junior psychiatrists, as the issue merits further debate. Unfortunately, I feel unable to agree with his views and fear he has missed the point of my original letter.

Dr Trigwell argues that psychiatric research has enhanced psychiatric practice through rigorous methodology, objective measuring tools and avoidance of assumptions where possible. Mention of the basic assumptions underlying the theoretical framework within which such research is carried out was avoided. Here the issues become more complicated and circular thinking a headache. Without an aetiologically based framework and concrete investigations, the 'gold standard' against which all the measures used are validated become a matter of consensus (of those in the most influential positions). In a profession where the subject matter upon which and within which our work takes place is that of subjective experience, the question of how research findings relate to patients' experiences is crucial. Here research papers often stop at a level of superficiality and without any deeper than surface attempt to understand the meaning behind the findings. Objective facts so often miss the essence of subjective reality.

Dr Trigwell criticises psychotherapeutic, particularly psychoanalytic, theory and practice, as lacking evidence of validity and usefulness, citing the crisis facing psychoanalysis in the USA as an indication that its place in psychiatric practice is in question. Psychiatric practice in particular, and medicine in general, is a victim of cultural trends and fashion as much as any other product of culture. It is an example of cultural imperialism to imply that what happens across the Atlantic represents what is inevitable or desirable more generally. Psychoanalytically orientated psychotherapy is still practised widely in the USA, has become very popular in South America in recent years, it is used much more extensively in the rest of Europe and has recently broken new ground in Eastern Europe. That psychotherapeutic theory and practice is constantly undergoing reassessment is part of its development.

The most common reason for trainees undertaking research is to secure senior registrar posts and to fulfil the expectations of their seniors. I agree with Dr Trigwell that academic knowledge and therapeutic competence should not be mutually exclusive, however, a trainees' time and personal resources are not limitless. In a psychiatric hierarchy which places high value on research to progress one's career with little recognition given to psychotherapeutic training (indeed it is often a disadvantage to express such an interest), it is little wonder that many trainees feel persecuted by the necessity for research and are discouraged from pursuing psychotherapeutic experiences.

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