and of education, with a tendency to favour the former over the latter when the induction day is local. To some extent we have succeeded in circumventing this conflict in SW Thames by combining local induction days with a regional induction for trainees new to the rotation. The regional induction day is organised to address educational issues, including psychotherapy and research opportunities. This has the additional advantage of engendering a sense of cohesion in the rotation as a whole.

My suggestion is that the practical difficulties of organising regional induction days are eventually justified by sustaining the morale and quality of a rotation, freeing the local hospitals to concentrate on service provision.

JOHN FARNILL MORGAN, *Registrar and Chairman of SW Thames Junior Doctors Committee, Epsom District Hospital, Epsom, Surrey*

Supervision of trainees

Sir: The regular individual supervision of trainees by their educational supervisors is a requirement of the College for a training scheme to retain approval. The 'Statement of training schemes for general professional training for the MRCPsych' (*Psychiatric Bulletin*, 1994, **18**, 514–522) lays down clearly what the College requires but with respect to the issue of individual supervision the document could be interpreted in more than one way. This has important implications as failure to comply with the standards laid down in the statement could lead to approval for a scheme being withdrawn.

In paragraph 5 (a) of the 'Organisation' section it is stated that "It is required that an hour a week is spent by the educational supervisor with the trainee on his or her own – not for the purposes of carrying out psychiatric management". This seems straightforward and is the standard that most educational supervisors try to attain. In paragraph 1 under 'Types of teaching', however, regular direct supervision can be individually or in small groups, suggesting that this must be describing supervision additional to the required individual hour. That the rest of this paragraph describes the need for clinical supervision of the management of new and follow-up out-patients reinforces the impression that this is not the supervision described earlier in the document. It is the presence in this paragraph of the statement "Such supervision should occur at least weekly for one hour", that gives rise to the confusion.

Some College officials (including the members of the panel on a recent College approval visit) seem to interpret this document to mean that educational supervisors should be setting aside two hours per week to spend individually with their trainee, one hour for case management issues, the other hour expressly for any other purpose. Others say that it is the hour for non-management issues that is mandatory, and that while adequate supervision of the trainee's management of patients is essential and should include presentation of cases to the supervisor, supervisors are not required to set aside a further hour each week purely for this purpose. I hope that this can be clarified before supervisors who conscientiously provide an hour of supervision per week find themselves penalised for not providing two, or alternatively unnecessary disruption is caused to clinical service provision throughout the country as supervisors rearrange their working weeks to provide an extra timetabled hour of supervision in the mistaken belief that this is what the College requires.

J. J. CLARKE, *Thorneywood Child and Adolescent Psychiatry Unit, Porchester Road, Nottingham NG3 6LF*

Sir: I am grateful to Dr Clarke for bringing to my attention a possible ambiguity in the Approval Statement of Training Schemes from the Court of Electors.

Dr Clarke is, of course, correct in his opinion that the Court is concerned to ensure that each trainee has one hour 'face-to-face' general supervision with an educational supervisor (consultant) each week. Such supervision is independent of, and additional to, the clinical supervision which the educational supervisor is also expected to provide with regard to the management of individual patients. Such clinical supervision may occur within a multidisciplinary team, ward round setting or general practice health clinic.

The content of the weekly general supervision, as implied within the Statement, does include career advice, assistance with basic interviewing skills, and feedback about

both positive and negative aspects of the trainee's clinical practice. It *is* likely, therefore, that a consultant will spend up to two hours each week in individual conversation with a trainee; although this will vary according to the needs of the trainee and the management style of the consultant. For example, *clinical* supervision may occur with a group of trainees, or in the setting of a multidisciplinary review.

The general supervision relating to career advice, clinical methods and clinical instruction is *always* an individual meeting between the trainee and the consultant. It is, therefore, the express intent of the College that there should be one hour of protected time when the trainee and the educational supervisor are together to discuss non-clinical issues. This is regarded as a benchmark of an adequate learning situation, and is necessary for approval of an individual post or rotation.

The Statement of Approval will require slight revision in the light of expected new basic specialist and higher specialist training grades, and this opportunity may be taken to clarify this possible ambiguity pointed out by your correspondent. Furthermore, we are considering more detailed advice to educational supervisors as to how this general supervision may be carried out: a meeting is planned at the College in the summer of 1995.

JOHN COX, *Dean, Royal College of Psychiatrists*

Sir: We were interested to read the findings and recommendations of Drs Herriot, Bhiu and Lelliott (*Psychiatric Bulletin*, 1994, **18**, 474–476) to improve the quality of supervision provided to trainees. In fact, we have recently completed a year long audit cycle aimed at improving the quantity and quality of supervision provided by an individual consultant.

We found that prior agreement of an agenda of items, with mutual commitment to preparation prior to sessions, significantly improved the subjective quality of supervision for both parties. Sufficient flexibility to tailor sessions to trainee's changing needs was incorporated by having regular reviews whereas the temporal regularity of sessions enhanced attendance. Although agreeing that the acceptance of standards of supervision for an entire training scheme is necessary, it is apparent that there needs to be clear commitment from both trainer and trainee at an individual level for this to be effectively enacted.

The audit of individual supervision is simple to perform, improves standards, and can act to reinforce this commitment. We can recommend it.

DAVID LAWLEY, DEREK PROUDLOVE, and JOHN BESTLEY, *De La Pole Hospital, Willerby, Hull*

Lithium monitoring

Sir: Having recently completed a similar audit of lithium monitoring, I read with great interest the article by John R. Taylor and Ian G. Dewar (*Psychiatric Bulletin*, 1994 **18**, 620–621). However, as opposed to the monitoring of in-patients, the aim was to follow up over a 12 month period all patients who were discharged from hospital on lithium between January and May 1993. In addition, as from the results of a previous audit that the highest proportion of 'revolving door patients' are those suffering from bipolar affective disorder, close and effective monitoring is all the more necessary in an attempt to improve compliance and reduce the need for readmission.

I agree that improvements in future monitoring depend on close liaison with other professionals, particularly with regard to patients in the community. However, the results of the out-patient audit reveal that the level of monitoring of serum lithium, renal and thyroid function is far superior in those patients who attend the clinic nurse in the out-patient department than those monitored by the community psychiatric nurse or general practitioner in the community. In addition, if patients default from their blood monitoring or are found to be non-compliant with medication, then they, and the relevant medical team, are immediately contacted.

Although I understand that the audit examined a selective group of patients taking lithium in that they had all been recently discharged from an in-patient unit, I feel that the results emphasise the need for a single, effective monitoring service where a register is available of all relevant patients.

STEPHEN NOBLETT, *Parkside Hospital, Macclesfield SK10 3JF*