not only an uncertain future for those of us trying to complete our training but also has wider implications in terms of the quality of clinical work we can provide whilst awaiting a substantive post. A trainee seeking such a post faces a task not dissimilar in challenge to the MRCPsych but more unpredictable and demanding with an unknown syllabus, uncertain standards and considerably more subjective methods of assessment. The drive to get shortlisted and successfully interviewed calls on us to read extensively about management in the NHS, upgrade curriculum vitaes, attend mock interviews and pay frequent visits to potential employment sites. While each of these activities may be beneficial to us in more ways than simply getting a job, we are pressured to pursue them feverishly and often at the expense of spending the extra clinical time with patients, an activity which is forced to rank low in priority in the minds of candidates and sometimes it seems even interviewers. A further not uncommon situation is one in which several trainees in the same unit or perhaps in the same clinical team are competing for the same job, creating interpersonal tensions which cannot be good for patient care.

It is a paradox that in a time when psychiatry is promoting the values of multidisciplinary community teams with open communication, shared responsibilities, diplomacy and consensus decision-making, psychiatrists in the later stages of training must divert their energies from clinical matters and be forced to compete with each other. Competition between different units to improve standards and quality of patient care makes sense but competition between peers is surely not going to produce future psychiatrists of integrity and humanity nor serve our profession in the long run. One aspect of psychiatry that attracted me to it as a career path was my belief that our greater psychological orientation than that in other branches of medicine would engender greater understanding and support for each other. Did we not enter psychiatry to cooperate rather than to compete?

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Use of internal locums

DEAR SIRS

It has been my pleasure to work as an internal locum over the last six months. There can be little doubt that the appointment of such posts will grow predominantly on economic grounds, as it is clearly cheaper to employ a full-time locum (costing £15,000 per annum), than to employ individual locums for small periods of time each (costing about £25,000 per annum). There are, however, advantages and disadvantages for the person in the post.

The main advantage is that the postholder has guaranteed employment for a set period of time. It is also a useful exercise in time management as one has to take over and hand back patients on an almost weekly basis. At times this is quite daunting and on Monday mornings I often had the feeling that we all have on returning from our holidays in that waiting on the unit were a dozen or so patients whom I had barely met before; and there were the dozen or so from the previous week who still thought I was dealing with them!

Disadvantages were mainly trivial. How was I to be paid? Weekly? Monthly? As a temporary doctor or a permanent locum? Either way the money came. One matter that was not trivial, however, was the question of approval for training. Fortunately my post was approved as a training post, but only after I had started was the matter finally resolved. I believe that it is crucially important that these posts are, wherever possible, approved. The consequences of not doing so will result in a poorer standard of applicant. The financial recompense for the doctor is not singly sufficient to compensate for that Monday morning feeling.

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Overcoming trainee inertia

DEAR SIRS

I would like to thank those who have spoken or written to me about the contribution 'Thirty-six Questions for the MRCPsych' (*Psychiatric Bulletin*, February 1991, **15**, 116–117).

Those who have tried to use the recommended programme have asked two main questions:

"I have not been able to get my SHOs or registrars to do the work required by your programme – especially the essays. Is there any sanction I can apply to make them do it?"

Whether students and trainees should be free to choose which academic activities in which to participate, or be compelled to attend required activities has been a long-running debate.

What is needed is a balance between the tutor's willingness to provide teaching and guidance outside Ward Rounds, and the trainee's recognition that it is good for him. Overcoming 'trainee inertia' is a matter of perseverance.

"I have tried to compress your 36 questions into a format to fit a six month rotation, but it doesn't quite work. Any suggestions?"

Yes. I have a version of the recommended teaching programme designed for use during a six month

rotation. If any tutors would like a copy would they please contact my secretary, Mrs Sue Knott.

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Careers in rehabilitation psychiatry

DEAR SIRS

The paper on Careers in Rehabilitation Psychiatry (*Psychiatric Bulletin*, November 1990, **14**, 665–667) covered the training requirements, job structure and potential frustration. Scrutiny of the forms filled in by College Representatives on Advisory Appointment Committees on Rehabilitation Consultant posts in England and Wales shows that there were 17 completely new national advertisements for consultant rehabilitation jobs in 1988, 21 in 1989 and 18 to 30 September 1990 (56 posts in all). Thirty-five appointment committees were held during this time, 26 rehabilitation jobs were filled, nine posts were not filled at the appointment committee stage.

Many health districts in England and Wales have advertised for a rehabilitation consultant but have been unsuccessful in appointing. Some health authorities persisted; for example, three posts were filled one year after the first advertisement. Unsuccessful health authorities may often alter the job or change local consultant responsibilites to assume rehabilitation commitments.

The Social, Community and Rehabilitation Section guidelines indicate special responsibility for rehabilitation should take five sessions and district services should be run on the basis of one rehabilitation session per 30,000 population. The recent audit of appointments shows that the sessional commitment for new consultants varied between two and ten.

There has been a considerable increase in the establishment of senior registrar posts in both general adult psychiatry and old age psychiatry (*Psychiatric Bulletin*, November 1990, **14**, 696). Rehabilitation psychiatry senior registrar posts are not specifically designated.

There are 18 rehabilitation consultants recognised as trainers of senior registrars in England and Wales (compared with six in 1984). These one year slots are not filled regularly, however, because senior registrar rotational schemes have more training places than higher professional trainees. In addition those taking the option may have no intention of becoming rehabilitation consultants.

A survey of consultant psychiatrists assessing career choice and appropriateness of training (*Psychiatric Bulletin*, January 1984, **8**, 2–5) revealed that the majority rated their training in rehabilitation as unsatisfactory.

Our audit of appointments shows that only 15 out of the 27 successful applicants fulfilled the criteria for rehabilitation experience promoted by the College. Seven senior registrars were appointed without appropriate training and a further five were appointed proleptically. Only a quarter of those interviewed had adequate recognised rehabilitation training.

The Department of Health has agreed that each region in England and Wales should have at least one rehabilitation consultant and that person should be recognised as a senior registrar trainer. With at least 20 consultant rehabilitation posts being advertised per year supply is not keeping up with demand. We suggest that each region should have at least two senior registrar training posts, until the present short fall is corrected and rehabilitation services for people with long term mental illness are more uniformally established.

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Chairman of Social, Community and Rehabilitation Section

Patients participation in examinations in psychiatry

DEAR SIRS

In response to the correspondence by Dr Lynch (*Psychiatric Bulletin*, May 1990, **14**, 308), the American Board of Psychiatry and Neurology currently organises three oral examinations in general psychiatry and one oral examination in child and adolescent psychiatry per year. Approximately 1,500 patient examinations are conducted in general psychiatry and 180 in child and adolescent psychiatry.

To our knowledge, there has never been a study similar to that conducted by Drs Persaud and Meux (*Psychiatric Bulletin*, February 1990, **14**, 65–71).

However, there is much anecdotal information that is obtained in the course of the examinations and following these examinations. It is our impression that there is not a similar level of morbidity and relapse following the examination experience. This may, in part, result from different methods and criteria for patient selection. For the American Board of Psychiatry and Neurology oral examinations, patients are not exclusively recruited from in-patient services and, indeed, many are out-patients as well as day care patients and, hence, the potential for decompensation following the examination may be less likely. Also, the examination is a one-half hour examination with the patient and the candidate in the room with two examiners at all times and a third