traditional remit of research ... be included ... in what is valued and therefore valuable for career progression".

We would, however, continue to maintain that research opportunities are there for those who seek them, even if they are not exactly handed out on a plate although the position for registrars and senior registrars is different. Senior registrars are given sessions (usually two per week) to carry out research. What are they doing with this time?

As a comparison may we give as an example students on a part-time Masters in Community Care course run by one of us (JMA). These students are in full-time jobs, may or may not be given one day a week to do research and (as part requirement for the degree) in a 12 month period plan, carry out and write a 20,000 word thesis on a piece of research of their own choice. Yes, they have a university supervisor but many receive little or no support (practical or psychological) in their job. Maybe the carrot of MCC after their name (but without the flashy tie!) is enough to motivate them. Or maybe they are looking for career advancement, an opportunity to learn and develop new areas and skills, maybe they are all masochists ... whatever their motivation it does demonstrate what can be accomplished in a limited period of time, with limited resources – given the will.

JACQUELINE M. ATKINSON
DENISE A. COIA

Department of Public Health
University of Glasgow
Glasgow G12 8RZ

DEAR SIRS

The paper by Atkinson and Coia on 'Trainees and Research' (*Psychiatric Bulletin*, June 1993, **17**, 355–356) makes some valuable comments on the issues, but I believe omits some of the main reasons for trainee research. In SW Thames successful applicants for senior registrar posts have at least one publication and usually more; however, it is important to examine the skills which have been acquired in the publication process, rather than the research *per se*. Compared to trainees who have not published, trainees with a list of publications will have picked up some computer skills, be familiar with word-processing, have carried out literature searches, and improved their writing skills. Perhaps most importantly, they will approach their everyday clinical work with the same level of mental scrutiny as they would a research problem.

I agree with the benefits to be gained from being part of a larger research group and also see this as a means of acquiring the above skills. Often there is a body of knowledge which the trainee may not be a party to, such as who to approach for some basic teaching in computer skills. Joining an established group can ease the acquisition of such knowledge.

The original research paper is rightly quoted as being unrepresentative of trainee publications as a whole, and review articles, case histories and audit are also mentioned as sources for publication. In addition, general practice journals and student journals generally welcome articles on psychiatric topics and there is a ready market for articles on management or administrative approaches in which trainees may be involved. Everyone will have an opinion on the articles that appear each week in the journals, so why not submit these opinions to the editor in the form of a letter?

The advantage of publications on a CV should be seen as evidence of skill acquisition and continue to be rewarded as such.

TOM MCCLINTOCK

Chairman, Psychiatric Trainees
St George's Hospital Rotations
London SW17

Reply

DEAR SIRS

Dr McClintock makes a number of points with which we would agree. Certainly we would see the skills obtained through publishing to be part of 'research' in its widest sense but such skills need not be dependent on research-as-collecting-new-data, a point we make. We would simply reiterate that if these skills are valued, whether gained through research or publication, then thought must be given first to identify what the skills are, then how best trainees in all clinical situations, not just the main academic centres, can develop them.

JACQUELINE M. ATKINSON
DENISE A. COIA

Department of Public Health
University of Glasgow
Glasgow G12 8RZ

DEAR SIRS

As trainees working "in the periphery", we were interested to read the article by Atkinson and Coia (*Psychiatric Bulletin*, June 1993, **17**, 355–356). In particular, from our viewpoint as psychiatric trainees, their advice on what counts as research is useful. However if the emphasis on research in order to progress up the career ladder is to continue, the College needs to urgently address this issue which marginalises a large number of trainees.

Wherever one works some of the problems are the same. The first being one of juggling the priorities between clinical work, examinations and research (not to say family and other normalising social demands on one's time). As pointed out, there are

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also more specific difficulties for those of us working outside of teaching centres. Perhaps the most important is finding an interested and accessible supervisor. Also, there is a very different ethos regarding research in peripheral and teaching hospitals. This acts as a pervasive and potent factor which discriminates between the trainee in each setting.

There does at present appear to be a drift towards expecting trainees to have published research earlier and earlier in training. If this is the College's intention then time for research must be put aside at registrar level. The article described the practicalities of carrying out research but it is more pertinent to pose the fundamental question of whether it is beneficial to expect this of registrars in psychiatry. Indeed, attention needs to return to emphasise high quality and diverse clinical experience. The authors accept that the first reason registrars do research is "to get a job". The emphasis at senior registrar interviews appears to be on two issues. First, the candidate's performance in the interview situation (which we suspect is not the best way of assessing ability to a competent consultant) and second on research.

Perhaps it is time to change the basic ground rules. With the expected 'streamlining' of the career structure in psychiatry with *Achieving a Balance*, we need instead to look at how to assess clinical and managerial abilities directly.

The importance of research, particularly at a registrar level, should be kept in perspective. Then perhaps we can feel more secure that the career opportunities are given to those most capable of doing the job.

R. J. Potter

"Trehafod" Child & Family Clinic
Cockett
Swansea SA2 0GB

M. B. O'Brien

Cefn Coed Hospital
Swansea SA2 0GH

The community component of liaison psychiatry

Dear Sirs

I read with interest Dr Kraemer's letter (*Psychiatric Bulletin*, June 1993, **17**, 371–372). I agree with him wholeheartedly, recognising the need for liaison psychiatrists' presence in other hospital departments, for example on medical ward rounds. Having been a trainee in liaison psychiatry at the Whittington Hospital I feel fit to ask Dr Kraemer, "What about the essential community component of liaison psychiatry?"

The majority of referrals (40%) come from hospitals. I demonstrated this by an audit (unpublished) of the liaison team at the Whittington Hospital covering the period from September 1991 to August 1992. The single largest source of patients referred from the community were from GPs who referred 30% of patients. The team also generated work for GPs by re-referring patients (38% of GP work generated by the liaison team) and by making new referrals (62% of GP work generated by the liaison team). Undoubtedly, there is a need for liaison psychiatrists in the community.

It is important to note that Kendrick *et al* 1991 found among GPs an almost complete lack of specific practice policies for the care of long-term mentally ill patients.

Reuven Manfred Magnus

Psychiatric Day Hospital
Whittington Hospital
London N19 5NF

Reference

Kendrick, T., Sibbald, B., Burns, T. *et al* (1991) Role of general practitioners in the care of the long-term mentally ill patients. *British Medical Journal*, **302**, 508–510.

Interview with Professor Robert Cawley

Dear Sirs

The interview by Hugh Freeman (*Psychiatric Bulletin*, May 1993, **17**, 260–273) reports Professor Cawley's difficulty in remembering anatomy as a medical student but there would appear to be other lapses of memory. He is reported to have said that "There was also Myre Sim, he tried to teach me something." He omitted that Professor Hogben arranged a Hailey Steward Research Fellowship with the Royal Society so that he could work with me on the problem of psychiatric diagnosis. Professor Hogben had been interested in my concern with the inadequacy of psychiatric labelling and its substitution by a vignette and which he had already noted when he was at the War Office (Sim, 1946). Dr Cawley and I elaborated on this concept and tested it out with the collaboration of my late colleague, Dr R. W. Tibbetts. It was very similar to a multiaxial system which has since been identified with the name of Michael Rutter and was adopted by DSM-III.

It is not without interest that not only was Michael Rutter one of my medical students but was also my house physician and later senior house officer when the psychiatric diagnosis study was in progress. I have since elaborated it further (Sim, 1983, 1987). Professor Cawley regards the number and quality of Birmingham graduates who entered psychiatry as due to chance. With himself, Lishman, Rutter, Mayou, Tom Lambo, Harold Merskey, Paul Skerritt and Max Kamin (Australians) and very many others who have also achieved distinction, even the negative

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