change of method made it difficult to draw valid conclusions.

Such problems may be familiar to other trainees who have rotated into new posts by the time they reach the second stage of an audit. Other staff that have to be relied on in the absence of the trainee may be less well motivated and unclear as to the nature of the project. This can result in difficulties obtaining data and problems in interpreting it. Recommendations for change that may be enthusiastically made initially, assume a lower priority than day to day patient management issues unless their importance is repeatedly reinforced.

The difficulties encountered by rotating doctors wishing to gain audit experience would be reduced if each hospital and specialty could agree on a regular rolling programme of audit (Shaw & Costain, 1989). Involvement of the local clinical audit service may be helpful in setting this up. Whilst emphasis is placed on the importance of 'closing the loop' by repeating the examination of data in six months or a year, this usually creates problems for the trainee and often means projects being started by one person and completed by another (Cook & Langa, 1994). Time allocated to audit for the trainee might enable projects to be successfully completed despite job moves rather than abandoned, as often happens at present. Trainees are likely to continue to be frustrated by the audit process until sufficient time and back-up are made available.

COOK, A. & LANGA, A. (1994) A trainee's view of basic issues in audit. *Psychiatric Bulletin*, **18**, 477–479.

SHAW, C. D. & COSTAIN, D. W. (1989) Guidelines for medical audit: seven principles. *British Medical Journal*, **299**, 498–499.

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Psychiatrists in management

Sir: I wish to draw to the attention of the College an exceedingly worrying obstacle to the involvement of consultant psychiatrists in management.

During negotiations with our trust management concerning the post of medical director we agreed that the director should have six-ring fenced sessions in which to perform his or her duties – the staff side would, in fact, have preferred eight. We then realised that such a medical director would lose mental health officer status for the duration of his or her appointment and that, in fact, any consultant who has mental health officer status would lose it if he or she engaged in more than two sessions of managerial work.

Clinical directorships possibly, in small trusts, can be done in two sessions but in our case, being a mental health trust covering a population of half a million, two sessions would be hopelessly inadequate.

My purpose in writing is two-fold. First, to draw to the attention of Members and Fellows, this potential threat to their pension rights – for every year served as a medical manager with three or more sessions devoted to managerial work there will be a need to work a year extra beyond the expected retirement age and this needs to be borne very carefully in mind by those tempted to apply for such posts. Second, I believe it is the duty of the College to take this matter up with the Department of Health and the pensions agency since it represents a disincentive specific to psychiatrists and of confounding proportions, to them becoming involved in management in anything other than a minor role. This disadvantages psychiatrists and psychiatry. It is, I would suggest, also a quite irrational position for the pensions agency to take since, if anything, being a medical manager of a psychiatric trust is more rather than less stressful than patient contact for which, of course, the mental health officer arrangements were designed to compensate.

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Editorial note. See also 'NHS superannuation regulations'. *Psychiatric Bulletin*, 1994, **18**, 713 and letters from Dr Ian G. Bronks and Dr M. J. Harris, *Psychiatric Bulletin*, 1995, **19**, 323–324.