are none other than the authors themselves! By the same token, should it transpire that they prefer to talk about patients for less than five minutes, it does not follow that such brief conversations are generally felt to be adequate by colleagues.

What my wife and I actually drew attention to, was the danger that "these hurried conversations may be substituted for the often more thoughtful formulations which are encouraged by the process of writing a traditional referral letter". Darling & Tyrer make a similar point when they acknowledge that sporadic contacts may be in danger of promoting a spurious sense of understanding. I would count it a sad day for psychiatry if general practice liaison resulted in large numbers of us "going native".

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DEAR SIRS

Dr Wilson is strictly correct in pointing out that his article in 1985 did not state directly that short contacts with general practitioners in liaison psychiatry were less attractive to psychiatrists. However, the implication was given that such contacts were undesirable and readers can judge whether this view is reinforced in his letter. We did indeed record some subjective aspects of liaison, whether the contacts were felt to be useful to both the initiators and receivers of each contact, but were restrained by space in our paper.

Although most of the contacts (94%) were judged to be of value to psychiatrists, general practitioners and other primary care team members, significantly more of the contacts initiated by GPs were not felt to be of value to the psychiatrist (20%; $\chi^2 = 23.6$, df 2, $P < 0.001$). In interpreting this finding it is important to realise that all contacts initiated by psychiatrists were of patients referred to, or already in, psychiatric care, whereas many GP contacts were of patients treated entirely by the primary care team.

We are not advocating short contacts as an ideal form of liaison. It is not a satisfactory form of communication on its own, but when taken in the context of other forms of service can reinforce continuity of care and save considerable time. Above all, it allows the opportunity for liaison, clinical assessment and treatment to be part of a comprehensive primary care service that buttresses the resources available to the general practitioner and helps to reduce the need for hospital treatment (Tyrer *et al*, 1990). It is premature for Dr Wilson to conclude that 'going native', a phrase that is patronising to both psychiatrists and general practitioners, would be sad for psychiatry. In any case, we would rather be part of a primitive service that is valuable to patients than a sophisticated one that is ineffective.

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Reference

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Rotational training schemes

DEAR SIRS

While sympathising with Drs Madden & Lewis's concern about changes to current rotational training schemes with the implementation of *Achieving a Balance*, I would like to point out that there are some aspects of these new arrangements which will clearly benefit trainees (*Psychiatric Bulletin*, November 1990, **14**, 681).

Firstly, as they suggest, SHO appointments can easily be made for longer than one year to provide a job security for trainees while settling into a new career and undertaking the formal training required for MRCPsych Part I. The old SHO/registrar rotations within districts can remain but without the promotion to registrar.

Requiring Part I MRCPsych for promotion to career registrar brings psychiatry into line with other medical specialities, which in my view improves standards. It may also provide a point of entry for potential consultant psychiatrists and enables imaginative new rotations to be created at registrar level. While SHO rotations can remain within health districts, registrar rotations can be wider and inter-district similar to those available in many regions for senior registrar training. A three or four year registrar rotation provides the continuing job security that is required for Part II MRCPsych training but also allows a wider clinical experience which may include access to sub-secialities not available in all districts.

While the creation of a further three year registrar rotation may appear to lengthen the time in training,

in practice psychiatry is still a shortage speciality. Trainees can therefore be encouraged to apply for registrar posts as soon as they pass their Part I; thus it is anticipated that the length of time at SHO level will be relatively short especially for "high flyers".

The increased supervision of training both for SHOs and registrars required by *Achieving a Balance* is surely beneficial to all trainees. Career counselling for "stuck doctors" is obviously very important but is currently seldom carried out in a systematic way. *Achieving a Balance* requirements clearly remedy this. Regular and formal review of registrars' progress by a regional based committee is also surely to be welcomed.

Thus although the requirements of *Achieving a Balance* involves the local scheme organisers, regional advisers, clinical tutors as well as College convenors and their teams with extra work, rotational schemes can be devised which benefit trainees. In such cases "controversy, ill-feeling and loss of morale" should not occur.

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Discharge summaries

DEAR SIRS

With reference to the article in the series 'Audit in practice' entitled 'Audit of psychiatric discharge summaries' (*Psychiatric Bulletin*, October 1990, **14**, 618–620). I was somewhat concerned to note that there did not appear to be any attention paid to the fact that many general practitioners either read the discharge summaries to the patient, hand the summary to the patient so that he or she can read it, or leave the patient in the surgery with the summary conveniently placed in front of him/her while the GP attends to other matters.

While I agree that a good summary is important for the psychiatric notes, I would feel that the best method of producing a summary for the GP should consist of the name and address of the patient, a diagnosis not exceeding six words, and the current medication and whether or not there is follow-up from the psychiatric service and in what form this would be.

Possibly, given the fact that at Highcroft Hospital there are 23 psychiatrists, the average contact with GPs is so low that they have not experienced these matters.

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DEAR SIRS

As we cited in our *Bulletin* report 'Audit of psychiatric discharge summaries', we have conducted a questionnaire study of the 234 general practitioners who refer patients to Highcroft Hospital in order to determine their preferences for format of a discharge communication from psychiatric hospital (Craddock & Craddock, 1989). We asked general practitioners to choose their preferred summary from three specimen summaries and 208 (89%) general practitioners responded. The briefest summary (very similar to Dr Launer's suggestion) was chosen by only 8% of respondents; 26% opted for a full and detailed summary filling $2\frac{1}{4}$ sides of A4 typescript while the majority (66%) preferred a summary of intermediate detail (with a length of one side of A4 typescript). We used the same methodology to determine which specimen summary the 23 psychiatrists at Highcroft Hospital preferred to have filled in the case notes as a record of the admission: 74% opted for the detailed summary and 26% for the summary of intermediate detail. There was a significant difference ($P<0.001$) between the preferences of general practitioners and psychiatrists and we concluded that a single summary cannot adequately meet the needs of both psychiatrists and general practitioners.

We suggest that general practitioners are sent a summary on one side of A4 typescript which contains details specifically pertinent to the general practitioner's future management of the case (which will include many, but not all, of the 23 items we list in our *Bulletin* report). We believe that the general practitioner should also be sent a copy of the detailed hospital summary (which may be discarded if not wanted). Such a scheme would satisfy the preferences of 92% of the general practitioners we surveyed.

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Reference

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A form of drug audit in mental handicap

DEAR SIRS

The drug treatment of mentally handicapped patients in hospital and community is complicated by issues which do not arise as frequently in general psychiatric practice. In mentally handicapped people there is, first, the question of how their level of understanding affects their capacity to consent to treatment. Second, psychiatric diagnoses are often less clear cut. Third, abnormal brain structure and function may affect the response to drugs. Fourth, carers