

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.

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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 (unpub-

lished) 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.

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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