In addition, the following types of experience should be included in a senior registrar training placement.

Clinical
(a) Supervision by a named individual consultant with a special responsibility for providing the liaison service.
(b) Close liaison links should be established with at least one clinical department during the attachment.
(c) Out-patient work should be undertaken in a specialist liaison clinic held on the general hospital site.
(d) The opportunity should be available to supervise other professionals who are undertaking liaison work.

Education
(a) Participation in and attendance at case presentations and other joint teaching meetings held in other clinical departments.
(b) Experience in teaching medical staff such as house physicians and A + E staff.
(c) It is desirable for the SR to have the opportunity to undertake supervised research in an area of liaison psychiatry.

Management
(a) Experience of coordinating the running of at least one part of the liaison service.
(b) Experience in developing and completing at least one audit project.

The exact distribution of clinical sessions will depend on the local contract, but should amount to the equivalent of six sessions per week during a placement of at least 12 months.

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Trainees' forum

European Trainees Conference

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Trainees in psychiatry from across Europe met to explore psychiatric training issues at a conference organised by the Collegiate Trainees Committee of the Royal College of Psychiatrists on 29 June 1992 in London. Altogether 16 delegates came, representing nine different countries. Each delegate had been put forward by their own country's training organisation and was able to represent the view of the trainees in that country. There were several aims in having this meeting: to provide a forum in which to learn about the diversity and richness of the current training of psychiatrists in Europe; to explore ways in which trainee psychiatrists can promote and improve their own training in a European context; and to develop organisational structures that would give psychiatric trainees a voice in the evolution of European training standards.

There was a great diversity of training in Europe, not only for postgraduate doctors specialising in psychiatry, but also at medical undergraduate level. Both the boundaries of psychiatry and how best to train in the speciality varied greatly between countries. Child and adolescent psychiatry was a separate training in several countries, e.g. Finland and Germany, but part of general psychiatric training in the UK. Neurology was seen as an essential part of training in psychiatry in a number of European countries, whereas in the UK neurology was seen as quite distinct from psychiatry and there was no expectation that a psychiatrist had such training. Psychotherapy was seen as one of the core skills of a psychiatrist by all delegates, and great surprise was expressed that psychotherapy training was not mandatory in the UK, the only country where this

was not the case. Higher training varied from four years (e.g. Switzerland or Finland) to seven (the UK), with some countries having an entrance exam (e.g. Spain), others a midway exam (the UK) or exit exam (e.g Finland), and some no exam at all (e.g. The Netherlands), with no indication if this made a difference to the quality of psychiatrists being produced.

Linked to the question of boundaries of the specialty were the very difficult questions of defining both the core curriculum and minimum training standards. These questions had added urgency now that the Advisory Committee on Medical Training have asked the monospecialist sections to set up 'European Boards', whose function would be to supervise harmonisation of training and issue a certificate of training.

With the short time available it was not clear how the training schemes in different countries actually worked. For instance, does a system similar to the approval visits operate in other European countries, and, if so, what sort of voice do trainees have in its operation? Some countries, notably the Netherlands, the Scandinavian countries, and the UK, have well-established national psychiatric training organisations, but this is by no means the case across Europe. Should there be a European inspectorate, which would vet training posts? To what extent can a consistency of training be set up across national boundaries in a specialty which is culture bound?

A number of basic principles of training were felt to be essential in a European setting. These included: trainees to have a voice in their own training, both at local and national levels; training to be broad based, and to include biological, social, and psychodynamic approaches with adequate supervision; mandatory training requirements, such as a minimum number of hours of supervised psychotherapy; choice and flexibility in training to preserve the unique aspects of each country's psychiatric training; and training in research methods.

A core curriculum for European psychiatric training needed to be defined, as did the nature of adequate supervision and a system for approving good training schemes. A local tutor scheme for trainees which could provide career guidance and deal with local grievances would be valuable; in some countries this did not exist. Finally, the importance of a peer group was stressed.

At the end of the meeting a European forum was set up, with the following aims: the facilitation of sharing information about psychiatric training from a trainees' perspective in member countries; providing a forum for debate about shared topics, such as approaches to handling violent or dangerous patients; and evolving a common psychiatric language with which to explore common training needs and problems.

A system of rotating host countries was set up, with the Dutch trainees agreeing to host a second European trainees forum in the spring of 1993. Delegates coming to the forum would be empowered to represent the trainees of their own country, with a maximum of two trainee delegates per country, perhaps one senior and one more junior. They would transcend all psychiatric sub-specialities, and thus not represent just child and adolescent psychiatry or adult psychiatry.

A number of formidable problems remain to be overcome. A 'postbox' which can hold information and act as a clearing house needs to be created. In the absence of any other organisational form this is perhaps best taken on by one of the well-organised and funded national trainees organisations such as those in the UK or The Netherlands. It will take time to establish a 'European training consciousness' as people learn to trust and share. This needs to be balanced by an inevitable process of trainees moving on and new people taking their place, who have to repeat the process. An organisational structure needs to be established which can contain this and carry a continuing identity and purpose. A debate, however, has been started among the psychiatric trainees in Europe which can only enrich the training and practice of psychiatry, and ultimately the quality of care of patients with mental disorders.