

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

comment that their exposure to myself did not do them harm is a compliment and outside the 'play of chance'.

I attribute it to the close integration of our department with the mainstream of medicine and the foresight of Professor P. C. Cloake who organised a division of neurological studies which included neurology, neurosurgery, psychiatry and neuropathology. It was an excellent introduction to psychiatry and we had an arrangement for some house physicians, who also had clinical exposure to neurology, to do their surgical jobs with neurosurgeons and thus reinforce their basic knowledge of the brain. Undergraduate training included the attachment of a psychiatrist to a medical 'firm' where once a week the student presented a medical case to the psychiatrist and the psychiatric aspects were then evaluated. There is much more to tell.

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#### Reply

DEAR SIRS

I must have upset Dr Myre Sim, and I am very sorry about this. Of course I well remember his presence and his encouragement to myself and others. His responsibilities in Birmingham at the time I was a medical student were formidable. Aided by Dr Tibbetts, he took responsibilities for the psychiatric services in all the Birmingham teaching hospitals, with associated teaching of undergraduates and postgraduates. The two of them also had to carry the considerable weight of virtually all the private practice in the metropolitan area. On top of everything these activities entailed, Dr Sim's considerable energy and enquiring mind led to his contributions to clinical research, and of course his textbook (published after my cohort had departed), in its successive editions, speaks for itself.

He is not quite right in saying that my Halley Stewart (not Hailey Stewart) Fellowship was dedicated to work on his vignette approach to extending the power of psychiatric diagnosis. I had a different agenda in Hogben's department. I certainly remember

Dr Sim demonstrating his ingenious system to me, and discussing it with him, but I was not closely involved in the development itself or its trials, and alas I can claim no credit for the successes of the work.

Dr Sim has misread my allusion to the play of chance. My comment referred to the high proportion of members of my own year (at least 12 out of 100) who became psychiatrists – far higher than in any preceding or following year in Birmingham, and indeed higher than any year at any time in any medical school I have known about. The excellence of the teachers, however great, would be unlikely as a sufficient explanation of this peak, in output of embryo psychiatrists. (Moreover, of course, recruitment to psychiatry is not usually seen as the main objective of undergraduate teaching in the subject.) Dr Sim lists names of some of the people who graduated in Birmingham over the years and subsequently achieved distinction in psychiatry. Two of those he mentions were in my year, as were several people he doesn't mention. The others in his list were scattered through preceding and succeeding years. A steady trickle of outstanding people in a speciality may certainly reflect credit on those who provided the initial stimulus. A sudden effusion is different from a trickle.

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DEAR SIRS

I was very interested to read the conversation between Hugh Freeman and Professor Cawley (*Psychiatric Bulletin*, May 1993, **17**, 260–273) since I was registrar and senior registrar at Kings College Hospital when Professor Cawley arrived to take up his professorship. He does not present entirely accurately the state of affairs regarding catchment areas as they were at the time.

Professor Cawley overlooked the fact that there were two psychiatric wards offering approximately 60 beds for mixed sex patients at St Giles Hospital, part of the Kings College Hospital group which provided a catchment area service to East Lambeth when he arrived. Dr John Hutchinson had been working with us at St Giles for at least three years at this time. When I started as an SHO in 1970 there was one ward, C4, not undertaking a catchment area service and a second ward opened some years later, C3, whose consultant was John Hutchinson. This marked the start of our catchment area provision. Only the most disturbed and dangerous patients were not admitted to these wards so that Kings College Hospital was undertaking catchment area responsibilities before Professor Cawley arrived on the scene.