Royal College. However, it was decided that the Psychotherapy Section could best serve the interests on both sides of the border by alternating the venues North and South and by holding residential meetings to attract members from the more distant areas.

Dr Anne Jackson of St Brigid's Hospital, Ardee (in the South) was elected as Secretary and the writer (from the North) as Chairperson. It is hoped that this revival of the Psychotherapy Section in Ireland will initiate renewed interest and activity from the general psychiatrists.

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Alcohol history-taking

DEAR SIRS

We wish to report the inadequacy of recorded drinking histories in patients admitted to a psychiatric hospital. Cefn Coed Hospital in a general psychiatric hospital providing services to the county of West Glamorgan with a catchment population of 360,000. We performed a retrospective case-note study of 120 consecutive new admissions to the hospital.

In the study, the ICD-9 diagnoses were noted. Each set of notes was examined to test the adequacy of the drinking history recorded. They were then classified using the following system:

(a) no mention
(b) qualitative assessment, for example, "social drinker"
(c) quantitative assessment, for example, "10 pints of beer a week".

The drinking history may have been recorded more than once, for example, on admission by the duty doctor and again by the ward doctor during the patient's stay in hospital. It was noted whether the CAGE questionnaire (Mayfield *et al*, 1974) was recorded and if the drinking history was taken by a psychiatric trainee or a GP SHO in psychiatry.

There were 139 histories on 120 patients as some had more than one history recorded during admission. The case-notes were completed by 12 GP SHOs and five psychiatric trainees. Two consultant psychiatrists recorded a quantitative history in five patients with an alcohol related diagnosis. Excluding these five we were left with 134 histories.

A quantitative history was obtained in 57 (43%), qualitative history in 35 (26%) and no history in 42 (31%). There were no significant differences between the type of drinking history recorded and the age, marital status or religion of the patients. Eighty per cent of patients with a diagnosis of alcohol dependence or abuse had a quantitative history recorded compared to 43% of those with a non-alcohol related diagnosis. Fifty-four per cent of GP SHOs recorded a quantitative history compared to 25% of psychiatric trainees. Only once was the CAGE questionnaire recorded. This was in a 41-year-old man with a diagnosis of neurotic depression and it was recorded by a GP SHO.

The GP SHOs failed to record a drinking history in 25% of cases studied whereas the psychiatric trainees failed to record the drinking history in 45% of cases. This compares unfavourably with the psychiatric trainees in a London teaching hospital (Farrell & David, 1988) who failed to record drinking histories in 21% of cases. Seventy-eight per cent of histories taken by the Cefn Coed psychiatric trainees failed to contain a quantitative assessment compared to 47% of histories taken by GP SHOs. We suggest these findings indicate differing attitudes to alcohol dependence and abuse in our small sample of non-teaching hospital junior psychiatric doctors. This may reflect a more open and less judgmental approach by doctors who have opted for a career in general practice.

From our sample, 20% of admissions had a diagnosis of alcohol dependence or abuse. This group is well recognised as requiring a significant and important clinical commitment and as such, doctors should retain a high index of suspicion. Drinking histories should always be quantified. Routine use of the CAGE questionnaire as a simple screening procedure can act as an *aide-memoire* for more detailed history taking. We suggest that further research is required to assess the effect of junior doctors' attitudes to drinking on their alcohol history taking.

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Competition between pre-senior registrars

DEAR SIRS

I share Dr Double's concerns about the current position of pre-senior registrars (*Psychiatric Bulletin*, December 1990, **14**, 743). The present bottleneck between registrar and senior registrar grade means

not only an uncertain future for those of us trying to complete our training but also has wider implications in terms of the quality of clinical work we can provide whilst awaiting a substantive post. A trainee seeking such a post faces a task not dissimilar in challenge to the MRCPsych but more unpredictable and demanding with an unknown syllabus, uncertain standards and considerably more subjective methods of assessment. The drive to get shortlisted and successfully interviewed calls on us to read extensively about management in the NHS, upgrade curriculum vitaes, attend mock interviews and pay frequent visits to potential employment sites. While each of these activities may be beneficial to us in more ways than simply getting a job, we are pressured to pursue them feverishly and often at the expense of spending the extra clinical time with patients, an activity which is forced to rank low in priority in the minds of candidates and sometimes it seems even interviewers. A further not uncommon situation is one in which several trainees in the same unit or perhaps in the same clinical team are competing for the same job, creating interpersonal tensions which cannot be good for patient care.

It is a paradox that in a time when psychiatry is promoting the values of multidisciplinary community teams with open communication, shared responsibilities, diplomacy and consensus decision-making, psychiatrists in the later stages of training must divert their energies from clinical matters and be forced to compete with each other. Competition between different units to improve standards and quality of patient care makes sense but competition between peers is surely not going to produce future psychiatrists of integrity and humanity nor serve our profession in the long run. One aspect of psychiatry that attracted me to it as a career path was my belief that our greater psychological orientation than that in other branches of medicine would engender greater understanding and support for each other. Did we not enter psychiatry to cooperate rather than to compete?

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Use of internal locums

DEAR SIRS

It has been my pleasure to work as an internal locum over the last six months. There can be little doubt that the appointment of such posts will grow predominantly on economic grounds, as it is clearly cheaper to employ a full-time locum (costing £15,000 per annum), than to employ individual locums for small periods of time each (costing about £25,000 per annum). There are, however, advantages and disadvantages for the person in the post.

The main advantage is that the postholder has guaranteed employment for a set period of time. It is also a useful exercise in time management as one has to take over and hand back patients on an almost weekly basis. At times this is quite daunting and on Monday mornings I often had the feeling that we all have on returning from our holidays in that waiting on the unit were a dozen or so patients whom I had barely met before; and there were the dozen or so from the previous week who still thought I was dealing with them!

Disadvantages were mainly trivial. How was I to be paid? Weekly? Monthly? As a temporary doctor or a permanent locum? Either way the money came. One matter that was not trivial, however, was the question of approval for training. Fortunately my post was approved as a training post, but only after I had started was the matter finally resolved. I believe that it is crucially important that these posts are, wherever possible, approved. The consequences of not doing so will result in a poorer standard of applicant. The financial recompense for the doctor is not singly sufficient to compensate for that Monday morning feeling.

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Overcoming trainee inertia

DEAR SIRS

I would like to thank those who have spoken or written to me about the contribution 'Thirty-six Questions for the MRCPsych' (*Psychiatric Bulletin*, February 1991, **15**, 116–117).

Those who have tried to use the recommended programme have asked two main questions:

"I have not been able to get my SHOs or registrars to do the work required by your programme – especially the essays. Is there any sanction I can apply to make them do it?"

Whether students and trainees should be free to choose which academic activities in which to participate, or be compelled to attend required activities has been a long-running debate.

What is needed is a balance between the tutor's willingness to provide teaching and guidance outside Ward Rounds, and the trainee's recognition that it is good for him. Overcoming 'trainee inertia' is a matter of perseverance.

"I have tried to compress your 36 questions into a format to fit a six month rotation, but it doesn't quite work. Any suggestions?"

Yes. I have a version of the recommended teaching programme designed for use during a six month