

staff. If this is what they really mean their suggestions will prove difficult to implement for several reasons.

(a) Based on statistics available for our district this would cause a substantial (150–200%) increase in the number of patients needing consultant out-patient care and a corresponding (and very expensive) increase of consultant numbers (a figure some way ahead of that anticipated in *Achieving a Balance*). Without such consultant expansion, consultants will be permanently tied to out-patient clinics and the quality of other aspects of care given by consultants would be compromised.

(b) If all or most of this vulnerable group were under consultant care how will registrars gain necessary skills to manage this group confidently before they become senior registrars or consultants where greater clinical autonomy and less supervision may be expected?

(c) The main drawback with traditional out-patient care which we addressed in the paper is the often high default rate. There is no evidence to suggest that this should necessarily be lower in consultant-based care. Audit of this type of service should be a higher priority as the traditional model appears to be inefficient.

Our study demonstrates that there are few diagnostic (and therefore vulnerability) differences in attenders and defaulters. The priority development in this form of care should be to improve its efficiency by reducing the high default rates seen. It may be that this is due to the shortcomings of the actual method of care, rather than the grade of medical officer involved. Apart from audit of traditional models of out-patient care, we feel there should be more research on other methods of follow-up, e.g. transfer of out-patient clinics into general practice settings.

We would be grateful to hear from other colleagues who have studied this form of care or alternative methods of follow-up of chronically mentally ill patients.

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DEAR SIRs

In response to the letter from Drs Shah and Lynch, the key element in our original letter refers to the fact that registrars usually spend only six months in one post but they have omitted this phrase from the quotation they give.

The aim of our letter was to highlight the need to look at both service *and* training implications of current changes in service provision. We feel that this should be debated widely in the College and this view is supported by recent correspondence to the *Bulletin* (November 1990, 14, 681–682) as well as by Drs Shah and Lynch.

We do not believe that brief letters in the correspondence section can do more than highlight this problem. We are sure that this is a topical issue and that many options are being considered. We would be happy to describe our approach as part of widening such a discussion but we would not suggest that it is anything other than one possible way to tackle the problem.

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Medical students' participation in psychiatric out-patients' clinics

DEAR SIRs

Attendance at, and participation in, out-patients' clinics is an essential part of the training in psychiatry offered to medical students. It provides an opportunity for the students to assess relatively cooperative patients whose symptoms have not been modified by prior treatment. Unfortunately, there are problems surrounding this participation.

Many students find it distressing to be party to the mass interview of a patient and feel that some consultants are unsympathetic and inconsiderate in making patients endure these consultations.

Patients compelled to repeat their history before a 'crowd' of students have been known to change their stories, to the detriment of their assessment. An alcoholic man gave a perfect history of his condition to one student, but insisted (to the student's embarrassment) that she had misunderstood him when she presented his drinking history to the group.

Going through the initial clerkship by one student, and the subsequent presentation to the consultant and the group, can take up as much as three hours, further undermining the benefits of the consultation.

The needs of the patient and the students could be met equally if the new patient is clerked by a student for no more than one hour. The student and the patient then go in for a discussion for 15–20 minutes, with the consultant. The essential points are assessed and arrangements made for the care of the patient who, after no more than 1½ hours, goes home.

After the patient has left, the rest of the medical students join in and have a fuller presentation of the case, with discussion.