aware of these problems. Various approaches towards their amelioration have been suggested, including the following.

(a) For each training scheme to designate a trainee counsellor for consultation by trainees should they wish to discuss personal stress-related matters. Exactly who fulfils this role would vary from scheme to scheme. Some psychiatric tutors take this on themselves, though it is clear that this is far from universal practice. Indeed, many tutors believe that it is not appropriate for them to deal with such problems, and many trainees in turn worry that by revealing their problems to the tutor, they might be labelled as somehow "unstable" and have their career advancement prejudiced.

The CTC suggests that ideally the role should be filled by someone with appropriate training in counselling, who could be available at short notice, and who is idependent of the training centre itself. Trainees should know who this individual is, and the manner in which contact might confidentially be made. Of course, this is not to say that tutors or others involved with the training itself should refrain from taking on any counselling role. It will be up to individual trainees to consult who they will should they run into problems, but the availability of an independent counsellor can only serve to enhance the chances of trainees in trouble seeking appropriate and timely help.

(b) The support of peers should not be discounted. Fellow trainees are the only ones who really understand the stresses of individual schemes at any given time. They are therefore in many ways best placed to help trainees in trouble. Unfortunately, due to factors alluded to above, such peer support is often not terribly forthcoming. It is hoped that psychiatric tutors would take a lead in encouraging trainees to support each other. The election of a trainee representative should be encouraged, and he/she should see his/her role as facilitating support networks among trainees, as well as being the channel through which grievances can be aired. The election of trainee representatives to sit on various hospital committees, like the Division of Psychiatry and Training Committee, should also be encouraged. This would serve to facilitate flow of information from trainees to consultants and administrators, and give trainees experience in committee work. It would also enhance the role of trainees in decision making about broader issues of patient care.

(c) Regular meetings of trainees should be encouraged, and time allowed for trainees (expressly those in peripheral placements, who are often the most isolated) to attend such. Some training schemes organise regular groups for new intakes of SHOs/registrars, usually facilitated by a psychotherapist. This is very useful to some trainees, and should at least be on offer.

Of course, these measures will only provide the framework in which the necessary support happens. Without them, however, it can only be anticipated that stressed trainees will continue to "go it alone", with potentially damaging consequences for themselves and for their patients.

DAVID CASTLE,
Vice Chairman
OLA JUNAID,
Chairman
ROB KEHOE,
Secretary
Collegiate Trainees' Committee

Syllabus for MRCPsych Part 1

DEAR SIRS

I am writing to express my concern over an apparent anomaly between the declared syllabus for the Part I examination for the College Membership and the questions set in the recent Part I examination in October 1991.

The syllabus states that: "in neuroanatomy the candidate's knowledge of the brain and spinal cord ... should be updated as the basis of neurological examination and diagnosis. The motor and sensory systems and the autonomic nervous system should be understood to the same level".

The authors of a book of multiple choice questions, Dr Puri and Dr Sklar, have interpreted these requirements as *excluding* the autonomy and physiology of the limbic system, primarily because these areas are specifically itemised in the Part II syllabus (personal communication).

Certainly, questions appeared in the paper set in October 1991 on both the anatomy and physiology of the limbic system.

I would be grateful for clarification of this matter.

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Reference

PURI, B. K. & SKLAR, J. (1990) *Revision for the MRCPsych Part 1*. Edinburgh: Churchill Livingstone.

DEAR SIRS

Thank you for letting me see the letter from Dr Colgate. The content for both Part I and Part II of the Examination are set out in the Regulations. Dr Colgate correctly quotes the Regulations which give the content in broad terms.

Unfortunately, it appears that Dr Colgate has accepted the interpretation given in the book to which he refers. The Examinations Office has never, to my knowledge, hitherto given more detailed information

and the only published examples are the sample papers distributed by the Royal College. Dr Puri and Dr Sklar's interpretation is not that of the College. It may be useful to emphasise that the only guidance issued by the Examinations Office is that in the Regulations and the Sample Question Papers.

Dr SHEILA A. MANN
Chief Examiner

Predicting new patient non-attendance

DEAR SIRS

We were interested to read Dr Woods' study (*Psychiatric Bulletin*, January 1992 **16**, 18–14) suggesting that psychiatrists are poor at predicting non-attendance on the basis of the patient's referral letter. We have data suggesting that, within a particular clinic, more accurate prediction may be possible.

Recently, the rate of non-attendance at the new patient general psychiatry clinic conducted by the authors has been found to be in excess of 30%. We compared the referral letters of 18 non-attenders with those of 18 patients who had attended during the same three month period.

The two groups did not differ in age, sex, time of appointment offered, length of time between referral and appointment or in whether an urgent or routine appointment had been requested.

Marked differences were evident in the content of the referral letters, cross-tabulations using the SPSS system revealing significant associations between the patient not attending and the following four factors:
(a) the letter being addressed to 'first available clinic' rather than to a named consultant ($P<0.05$)
(b) the referral letter being handwritten ($P<0.001$)
(c) the letter containing no reference to a diagnosis, no matter how approximate or vague ($P<0.01$)
(d) the letter containing no reference to the possible reasons for the patient's problems, nor to their social situation or background ($P<0.01$).

In addition, a highly significant association was found between non-attendance and the patient not responding to a request, sent with details of their appointment, to confirm, by phone or letter, that they would be attending their appointment ($P<0.001$).

Stepwise logistic regression analysis suggested that the two most influential of these factors were the patients not confirming their intention to attend and the referral letter containing no reference to the reasons for, or context of, their difficulties. Taken together, these two factors correctly predicted whether the individual would have attended in 35 out of the 36 cases.

The strong correlations between non-attendance and elements in the referral letter may not have a simple explanation; however we suggest that there may be a relationshp with the psychiatric skills of the referring general practitioner, the handwritten referral letter, devoid of information other than the patient's symptoms, reflecting a hurriedly-made referral, possibly after a difficult interchange with the patient, who is himself uncommitted to the referral and who consequently ignores the letter he receives from the hospital.

A new patient non-attendance rate of 30% is undoubtedly costly in time and resources. These findings suggest that an effective way of reducing this wastage may be to identify patients at high risk of non-attendance by screening new patient referral letters for the four elements identified above and requesting information from patients of their intention to attend. Extra efforts could then be made, which may involve the GP, to contact these patients prior to their appointment. More radical approaches, possibly appropriate in view of the recent changes in the NHS, may be to include in contracts a charge for non-attendance or to make the new patient appointment, in non-urgent cases, conditional on confirmation from the patient.

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In conversation with Ivor Browne

DEAR SIRS

The interview by David Healy with Professor Ivor Browne (*Psychiatric Bulletin*, January 1992, **16**, 1–9) was most interesting and rewarding. As an Ulsterman, I was honoured to be Chairman of the Irish Division for a period during the past decade. At times I felt "all at sea" when chairing meetings in the Republic, coming from, and working in, the NHS system in the North. Now I understand more of the undercurrents medico-politically and thank those colleagues "in the know" for guiding me through hazardous waters. I could sense antagonism between protagonists, yet all were courteous, and none more so than Ivor who occasionally appeared to steer a course at odds with other viewpoints.

In an "off the cuff" conversation memory can lapse. That must surely have happened to Ivor about the University chair in Belfast. The late John Gibson became Professor of Mental Health at Queens University, Belfast in 1957, and developed psychiatry in N. Ireland for 17 years before his untimely death in 1974, to be followed by George Fenton, and now Roy McClelland.

Ivor is right when he alludes to worries which psychiatrists in N. Ireland had in the '70s which were why