defined (Table 1) the research concepts and skills which we teach; we think they are prerequisites for undertaking a research study and for critical reading of published work. We offer this summary to touch off a debate about the areas of research practice in which the College might set standards for trainees and (by implication) supervisors.

Once they are armed with a set of standards, research co-ordinators, approval panels and examiners may combine to guide trainees and supervisors towards better research practice.

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Comment

John Cox

In general I found this piece a constructive approach to the problems of training trainees in research methods. I would not dispute the importance of research training for future consultants. There are, however, issues as to when and how such training should take place – whether in general or higher professional training. There is certainly need for clarification about the extent to which all trainees should be involved with a research project involving data collection, rather than devising a research protocol or learning to critically review the literature. There is always competition for teaching time.

The editorial will also raise debate about the balance between Master's degree teaching and MRCPsych teaching. Increasingly I recognise areas of overlap but also recognise specific differences. Training to pass the Membership, which includes a strong academic content, is a different task from working for a University Master's degree. Universities, for example, vary in their approach to the duration and content of Masters' degrees. Keele, for example, has a part-time two year taught course *with* a research protocol which includes a full review of the literature; it also has specific MPhil and MD research degrees. Other universities, such as Leeds, Birmingham and Edinburgh have more prolonged Masters' degrees, with formal requirements for course attendance, and an expectation of completing a research project. Some medical schools also offer Masters' degrees open to non-medical graduates – an important innovative development which has specific advantages.

The MRCPsych examination undergoes continuous review, and is likely in future to

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include a critical review of a research paper. There is at the present time appropriate emphasis within the examination on understanding research methodology and having an adequate grasp of theory which underpins clinical work.

The authors will no doubt be disappointed that the Short Answer Question Paper is being discontinued after 1996 because if failed to discriminate satisfactorily between candidates.

John Cox, *Dean, Royal College of Psychiatrists*

Catchment areas: a model for the future or a relic of the past?

John M. Kellett

The shift of power from specialist services to the primary care teams has forced the former to examine the value of their hallowed traditions. In psychiatry, and geriatric medicine, the catchment area is a favoured restrictive practice, enabling demand to be regulated to suit the resources of each team. It is time to decide whether this is a practice to be defended and retained or whether, like many other restrictive practices, it is harmful to the consumer.

Origins

In the days of the workhouse it was appropriate to limit its use to the poor of the parish whose members subscribed to its upkeep. Generous parishes needed to be defended against the destitute vagrant from another area. So grew the notion of a catchment area, a notion that was promoted by the services which later occupied the poor law institutions. These services were under-funded as they were often regarded as of low priority and a device to limit demand was necessary if a service was not to be swamped.

Potential benefits and harm

Benefits

Responsibility for the difficult patient is clear.

Coterminosity promotes close liaison and cooperation with other services.

Each consultant team is guaranteed an adequate work-load.

Prevents over-specialisation.

Ensures contact with same team over time.

Harm

Prevents GP matching the specialist to the patient.

Reduces competition between consultants, thereby encouraging mediocrity.

Geographical boundaries do not fit with practice boundaries, thus preventing close liaison with a single general practice.

Discourages necessary specialisation.

Blocks opportunity to change specialist after bad experience.

Enforces change of specialist when moving house.

The above lists are clearly open to debate. Some would regard further specialisation as an inevitable consequence of the increasing sophistication of psychiatry, while others might regard this as a process which would accelerate burn-out. What cannot be denied is that the greater flexibility of open referral systems leaves more choice for the consumer.

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