Increased rates of suicide in farmers have been a cause for concern in agricultural circles in the recent past and are attributed largely to declining incomes. As well as direct financial worries, inclement weather, burgeoning bureaucracy and greater work load have all been cited by farmer's leaders as stressors. Current disquiet includes the possible effects of the export ban on live animals, and bovine spongiform encephalopathy (BSE) on returns.

In response to this crisis, local branches of the Farmers Union of Wales and the National Farmers Union, in collaboration with the Citizens' Advice Bureau and Samaritans, have commissioned an information leaflet and confidential advice line. While this initiative can only be applauded, it is uncertain whether the most vulnerable individuals will make contact and seek help. Past experience in less well defined target populations has not been promising (e.g. Kreitman & Chowdhury, 1973). Moreover, as a group farmers are traditionally noted for their stoicism and self-sufficiency, and are often isolated socially and geographically. Their relatively easy access to firearms should not be forgotten.

Suicide prevention is a feasible objective as pointed out by eminent authorities elsewhere (Hawton & Morgan, 1993). General practitioners and psychiatrists need to keep informed of putative trends if serendipitous contacts with members of high risk groups are to be exploited for averting suicide.

HAWTON, K. & MORGAN, H.G. (1993) Suicide prevention by general practitioners. *British Journal of Psychiatry*, **162**, 422.

KREITMAN, N. & CHOWDHURY, N. (1973) Distressed behaviour: a study of selected Samaritan clients and parasuicide ('attempted suicide patients'). *British Journal of Psychiatry*, **123**, 1–8.

The Country Times & Express & Gazette, 16 September 1994, p2.

KEVIN NICHOLLS, *Keele Rotation, City General Hospital, Stoke-on-Trent, Staffordshire ST4 6QG*

AIDS education

Sir: Dr Treloar (*Psychiatric Bulletin*, January 1995, **19**, 52) notes that I congratulate a Brazilian newspaper for promoting the message that "sex is good for physical and mental health" and quotes me as saying that sex is "safe with a condom". The first quote is correct but the second is not, what the newspaper actually said was "wear a condom", and this is how the quote appeared in my article. I doubt anyone would argue that condoms are "safe", but as the WHO study shows they are safer than doing nothing. Short of not having sex, there is still no measure that is completely safe. Safe-sex, or more accurately safer-sex, campaigns aim to give information on how to reduce risks and this was the message of the Brazilian newspaper.

The question of condom failure is a complex one. While the pores in condoms may allow leakage of HIV, whether this alone is sufficient to cause infection is less clear. Bodily fluids such as tears and saliva also contain HIV, but at levels which are not believed to be infective. Condom failure is often due to the condom coming off during intercourse or to tearing, which has little or nothing to do with its porosity. Some brands of condom are coated with the spermicide nonoxynol-9, which is viricidal and safe sex campaigns recommend its use with condoms so as to further reduce the risk of transmission. Anecdotal reports from Brazil suggest that some people are unaware that condoms cannot be used with oil-based lubricants, adding further to the risk of condom failure.

JOHN DUNN, *Departamento de Psiquiatria, Escola Paulista de Medicina, São Paulo-SP, 04023-900, Brazil*

'An induction day for trainees in psychiatry'

Sir: Dr McLaren and colleagues (*Psychiatric Bulletin*, 1994, **18**, 687–688) have presented a lucid account of the rationale behind the organisation of their trainees' induction day. This was of particular interest to me, as I had just helped to organise both local and regional induction days in SW Thames. Their description serves to highlight some of the difficulties which I faced in designing an appropriate programme.

I would strongly endorse the principle of serving "the trainees, the clinical tutor and the personnel department" but it may prove awkward to fulfil all these aims simultaneously. Often there is an unspoken conflict between issues of service provision

and of education, with a tendency to favour the former over the latter when the induction day is local. To some extent we have succeeded in circumventing this conflict in SW Thames by combining local induction days with a regional induction for trainees new to the rotation. The regional induction day is organised to address educational issues, including psychotherapy and research opportunities. This has the additional advantage of engendering a sense of cohesion in the rotation as a whole.

My suggestion is that the practical difficulties of organising regional induction days are eventually justified by sustaining the morale and quality of a rotation, freeing the local hospitals to concentrate on service provision.

JOHN FARNILL MORGAN, *Registrar and Chairman of SW Thames Junior Doctors Committee, Epsom District Hospital, Epsom, Surrey*

Supervision of trainees

Sir: The regular individual supervision of trainees by their educational supervisors is a requirement of the College for a training scheme to retain approval. The 'Statement of training schemes for general professional training for the MRCPsych' (*Psychiatric Bulletin*, 1994, **18**, 514–522) lays down clearly what the College requires but with respect to the issue of individual supervision the document could be interpreted in more than one way. This has important implications as failure to comply with the standards laid down in the statement could lead to approval for a scheme being withdrawn.

In paragraph 5 (a) of the 'Organisation' section it is stated that "It is required that an hour a week is spent by the educational supervisor with the trainee on his or her own – not for the purposes of carrying out psychiatric management". This seems straightforward and is the standard that most educational supervisors try to attain. In paragraph 1 under 'Types of teaching', however, regular direct supervision can be individually or in small groups, suggesting that this must be describing supervision additional to the required individual hour. That the rest of this paragraph describes the need for clinical supervision of the management of new and follow-up out-patients reinforces the impression that this is not the supervision described earlier in the document. It is the presence in this paragraph of the statement "Such supervision should occur at least weekly for one hour", that gives rise to the confusion.

Some College officials (including the members of the panel on a recent College approval visit) seem to interpret this document to mean that educational supervisors should be setting aside two hours per week to spend individually with their trainee, one hour for case management issues, the other hour expressly for any other purpose. Others say that it is the hour for non-management issues that is mandatory, and that while adequate supervision of the trainee's management of patients is essential and should include presentation of cases to the supervisor, supervisors are not required to set aside a further hour each week purely for this purpose. I hope that this can be clarified before supervisors who conscientiously provide an hour of supervision per week find themselves penalised for not providing two, or alternatively unnecessary disruption is caused to clinical service provision throughout the country as supervisors rearrange their working weeks to provide an extra timetabled hour of supervision in the mistaken belief that this is what the College requires.

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Sir: I am grateful to Dr Clarke for bringing to my attention a possible ambiguity in the Approval Statement of Training Schemes from the Court of Electors.

Dr Clarke is, of course, correct in his opinion that the Court is concerned to ensure that each trainee has one hour 'face-to-face' general supervision with an educational supervisor (consultant) each week. Such supervision is independent of, and additional to, the clinical supervision which the educational supervisor is also expected to provide with regard to the management of individual patients. Such clinical supervision may occur within a multidisciplinary team, ward round setting or general practice health clinic.

The content of the weekly general supervision, as implied within the Statement, does include career advice, assistance with basic interviewing skills, and feedback about