problems,[5] trainees in psychiatry should have some awareness of this type of approach and a knowledge of the strategies used. In this way, even those who do not wish to apply the techniques themselves will at least be able to select and refer patients appropriately.

Many psychiatrists not using CT harbour misconceptions about what is involved: that CT is only what clinicians do already; that it is unsuitable for endogenous-type depressives; that CT involves 'talking the patient out of their worries'. These and other perceived problems with CT are discussed by Williams.[6] Finally, some clinicians hold that CT merely systematizes good clinical practice. In fact, this type of treatment involves a particular therapeutic style as well as the application of a set of techniques and requires a significant conceptual shift for many psychiatrists. The patient and therapist must collaborate to carry out an empirical investigation of the patient's thoughts and assumptions about themselves, their world and their future. The aspiring cognitive therapist also needs to be able to conduct the sessions in a warm, empathic and accepting manner, gently challenging the patient to think of ways in which they can test out their maladaptive thoughts without making them feel they are being confronted. It therefore gives the trainee the opportunity to develop good psychotherapeutic skills in a more structured and directive setting than that usually afforded by dynamically orientated psychotherapy, although it by no means replaces teaching and experience in these other schools.

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An Open Letter to the President from the Collegiate Trainees' Committee

DEAR DR BEWLEY

At the present time there are 1,066 whole-time equivalent (wte) consultant psychiatrists practising in the field of adult mental illness in England and Wales. These consultants are training 248 wte senior registrars and 762 wte registrars. If the Short Report recommendations (of doubling the number of consultants and reversing the ratio of consultants to trainees) are implemented then 2,132 wte consultants will need to train approximately 426 wte senior registrars and no more, possibly fewer, wte registrars. (The ratio of five consultants to one senior registrar has been used which assumes an average working life of 20 years for a consultant and 4 years' training for a senior registrar. This ratio is currently used in Scotland, in all specialties, to calculate the senior registrar establishment, yearly, on the basis of projected consultant vacancies.)

The CTC is alarmed that despite the fact that the Government has accepted the bulk of Short's recommendations there is no striking evidence as yet of its implementation, with the lamentable exception of efforts to reduce junior posts without consultant expansion. As the College has also endorsed the bulk of the Short Report one might have expected more protest than has yet been seen.

However, even if the Short proposals are never implemented, the College's own long-term goal of one consultant to 25,000 population would also lead roughly to a doubling of the number of consultant psychiatrists and the institution of a realistic career structure in psychiatry would demand the same numbers of juniors as are derived above for implementation of the Short proposals.

Coupled with recent complaints that by setting more stringent requirements the Approval Exercise is affecting service provision (*Bulletin*, April 1984, **8**, 74–75; *Hospital Doctor*, 9 November 1984, p. 4), it would seem inevitable that in future a proportion of consultant psychiatrists will have to work without the support of trainees. There is therefore a need to face up to this unpalatable reality.

It has been suggested that the College should study those units already providing a consultant only service and also look more to the approval of posts rather than hospitals in order that more hospitals will maintain a trainee presence (*Bulletin*, July 1984, **8**, 122–23). Whilst the CTC would support these two suggestions and believes that all training schemes should incorporate posts outside teaching centres, to prevent trainees being concentrated in the latter, there is also a need for wider action. Much of the reluctance to think in terms of a consultant provided service, both from seniors and juniors, must be attributable to the effects of training and working in one model of service.

In order that the prospect of working in this way is seen as a challenge by some, rather than a booby prize by all, it would seem logical to introduce this model of service during training—at a time when young psychiatrists are at their most creative—rather than attempt to impose it on mature clinicians out of necessity.

The CTC wishes to know when the College will grasp this nettle.

Yours sincerely,

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Chairman

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