The Scottish psychiatric scene differs in several respects from that of England. The Physician Superintendent is still a power in the land, though if the ones we met were despots they seemed remarkably benevolent ones. Scotland has been less than enthusiastic about general hospital psychiatric units, so that the mental hospitals have not been starved of resources. The provision of consultants generally exceeds the DHSS norm of one per 60,000 population. No clinical tutor is paid and many lack official status.

There were some features which cropped up sufficiently often to cause us some concern:

1. There are obvious dangers for training in the system in which a consultant is responsible for in-patients of one sex only. We found some trainees who had dealt with in-patients of one sex only for periods of over two years. Where this system survives it is important to rotate the trainees within the hospital to allow experience in treating patients of both sexes.

2. We were surprised by the high proportion of registrars in some hospitals who were not psychiatric trainees but supposedly studying for higher qualifications in medicine, surgery, paediatrics or obstetrics. They are said to be needed as pairs of hands but they have a markedly deadening effect on psychiatric training within the hospital. This is a problem that could perhaps be examined more closely by the College.

3. We found instances of trainees being responsible at one time to five or six different consultants. We preferred the team system with a trainee attached to one or, at the most, two consultants at a time.

4. Many trainees, particularly from overseas, were not taking advantage of the academic courses available in University centres. Apart from geographical difficulties we thought the courses would be more attractive if they started with clinical psychiatry rather than the traditional basic sciences. Special introductory courses for overseas trainees may also be necessary. More could be done within the hospitals to teach interviewing skills and note-keeping.

Despite these criticisms we found a generally high standard of training in Scotland, and the clinical tutors were all devoted to their task. We endeavoured to make our criticisms constructive, and in subsequent correspondence with the tutors it has been apparent that our visits have often had a marked catalytic effect in bringing about changes in practice and organization that had been long in prospect. That is, after all, the object of the exercise.

OBSESSIVE-COMPULSIVE AND AGORAPHOBIC PATIENTS: A REQUEST

An MRC-funded research programme is examining the effects of clomipramine or placebo combined with behavioural treatment in patients with obsessive-compulsive disorder who are prepared to be in-patients for 7 weeks. Out-patients with serious marital discord plus agoraphobia are also being studied with behavioural treatments. Enquiries about referrals may be made to Dr. Isaac Marks at the Institute of Psychiatry, Maudsley Hospital, London, SE5 8AF.

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