personally checked the applicant's references with his/her former colleagues. This should be a mandatory provision.

5. If applicants for short-term locum consultant posts do not meet the condition under (1) then either:

   (a) no appointment should be made
   (b) an appointment should be made at a grade appropriate to the needs of the service. If an appointment is made to a training grade, consideration should be given to the educational needs and consultant supervision of the trainee.

   In no circumstances should a candidate be appointed to a post in which he/she would have to "act up" beyond his/her trained capability. This would at best be inimical to the maintenance of standards and at worst dangerous to patients. Moreover it throws an excessive burden of responsibility upon other medical staff in the same and in associated specialities.

6. It has been noted that there is a national shortage of suitably qualified psychiatrists able to carry out locum consultant work. It has been agreed therefore that the College will forward to relevant College Regional Advisers the names of those-consultant psychiatrists who have recently retired and are willing to undertake this type of work on a short-term basis. A notice appears in the *Psychiatric Bulletin* at six-monthly intervals inviting retired members, interested in this type of work, to write to the Secretary.

7. Judgements of the Employment Appeal Tribunal have underlined the importance of careful consideration of locum tenens appointments. Evidence presented to this Tribunal has shown that some locums continue to hold their appointments for many years. On other occasions the appointment may be short and temporary. The Tribunal has pointed out that when a temporary appointment comes to an end it is the duty of the employing body to consider the position of the employee. What will then be appropriate will depend on the circumstances of each case (how long he or she has been employed, what the understanding was when the employee was engaged, what the circumstances are of the employing body and so forth). However, the irreducible minimum requirement is that the employee's position should be considered, and that he/she should not be treated upon the expiry of this short-term contract of employment as though he/she enjoyed no statutory rights at all.

Court of Electors
October 1991

Psychiatric Bulletin (1992), **16,** 57–59

The Research Committee's Proposal for Research Tutors

The Research Committee of the Royal College of Psychiatrists is proposing to set up a network of Research Tutors. This short article describes the proposals and invites colleagues who might be interested in developing such a role to contact me. The proposals have been discussed by the AUTP, Education Committee, Collegiate Trainees Committee and Council and have been endorsed by all these bodies.

Nearly all enquiries into why psychiatric trainees do not carry out research seem to finally focus on two issues. Firstly, the lack of interest in research by psychiatric trainees and secondly, the issue of lack of supervision. In our experience the first issue is not a particular problem. Not all trainees are interested in research but a great many are. Our view is that at this stage we should not necessarily be encouraging more trainees to do research but begin by encouraging and supporting those who do have ideas but whose projects seem to flounder for a multitude of reasons. It is our view that if we could develop an effective research tutors network so that trainees could see they were getting relevant advice and supervision gradually more trainees would wish to be involved in such a process. We would not wish to make research mandatory or put further hurdles in the way of a trainee's progress.

We think now is a good time to change. Although it is difficult to know exactly how the structure of training grades will develop, it is certainly possible that the MRCPsych examination will become less intrusive in a trainee's life because as trainees spend a little longer at the registrar grade they may have a year or more post membership in which to devote a little more time to research.

Over the last four years the Research Committee has run eight residential courses on research methodology and nearly 300 trainees have attended. We are aware that they were a self selected group who were prepared to give up their time and often money to attend such a course. They came from a wide variety of backgrounds including academic posts, training schemes attached to academic departments and training schemes quite remote from an academic centre. There seemed to be no shortage of research ideas or enthusiasm for research. What there was was a definite lack of supervision. Many of the trainees had embarked on projects that were far too large or

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complicated to be undertaken with the resources that they had available and they appear to have had little or no critical feedback about this. Similarly, there was little or no supervision of the ongoing conduct of research.

A few trainees felt alienated from University Departments of Psychiatry which were seen as distant, rigid and over critical and simply not having the time or resources to supervise trainees. The distance was sometimes literal, two trainees having a five hour return trip to get to their nearest academic library or to see a senior member of staff. The rigidity was associated with the feeling that certain departments had very clear ideas about what was and what was not valid psychiatric research and secondly the pressure to use certain rating scales and structured interviews to measure outcome, because these measures were in common use in that department.

What would be expected of a research tutor?

1. We are looking for people who are at consultant or senior lecturer level with some previous experience of research methods and preferably of getting grants. They would need to be prepared to give up some time for this.
2. He or she would operate at a local level with a group of 10 to 15 trainees. How this was organised would depend on local factors, such as geography, size of training scheme and closeness to University Department.
3. They might hold a register of local research projects and research interests.
4. They might hold regular small group research seminars where ideas could be discussed.
5. They might organise the local research methods teaching on the MRCPsych course or liaise with the University Department if this was already being organised by that Department.
6. They would have a general responsibility for promoting research among trainees, guiding trainees and offering specific advice.
7. They might keep a data bank of important research methods papers and books and a comprehensive collection of questionnaires and the papers supporting them. They would not necessarily be supervising all their trainees. It is unlikely that all 15 trainees would want to take part and for many it might be more appropriate that they be supervised by someone else.
8. The tutor would be involved in helping to find a supervisor where this was necessary and keeping some general overview of the progress of research among his or her trainees.
9. We would not want to be too prescriptive about the research tutor's role and clearly quite different models might develop in different areas.

What would the Research Committee do?

1. Recruit tutors, keep a register of their names, interests, and the models that they had developed.
2. Circulate tutors with reading lists, notes about recent articles on research, reviews of research methods books, up to date information on computer programmes etc.
3. Hold an annual conference where tutors could be updated on recent research methods and most importantly where they could get together as a group and exchange ideas about research, difficulties of supervision, etc.

Who might become a research tutor?

1. Tutors could be either NHS Consultants or academics and again this would depend on local arrangements. Some academic departments already have extensive networks of supervisors, Research Methods Courses and Research Supervision Seminars, and in these areas there might be no need for another tier of supervision.
2. It would be important for the research tutor to be enthusiastic about research and hopefully carrying out some research themselves. For potential tutors who had the enthusiasm but felt they needed more research methods training the Research Committee would be prepared to put on an initial two or three day course.
3. We think it would be important that if possible tutors were in post for a number of years and certainly for longer than the average life of a current clinical tutor. It takes several years to see a research project through from initiation to publication.

What would the tutor get out of it?

1. Hopefully the job would be an enjoyable and stimulating one.
2. Some of the trainees might want to be involved in the tutor's own research.
3. For tutors outside an academic centre and perhaps for some of those within it would provide a peer group.
4. We think it unlikely that such posts will attract an honorarium or sessions until the scheme is established and has proved to be worthwhile but this would be one of our long-term aims.

Proposed action

1. The Research Committee has set up a small working group to supervise this endeavour including myself, Peter Tyrer, Brian Ferguson, Patricia Casey, Trevor Silverstone and Robin McCreadie.
2. If you are interested in participating in such a scheme, please could you write to me at the College.

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3. We would plan to hold a one day open meeting some time in the early Spring where all interested parties could meet.
4. Following those discussions we would organise one or two day induction course, perhaps after Easter of 1992 and begin the scheme formally from that point.
5. Noting your interest at this stage and coming to the initial meeting obviously would not commit you to anything.
6. It is unrealistic to think that we could provide a nationwide network from scratch and we would plan to begin the network in a number of districts and build it up from that point.
7. Finally where efficient supervision already exists, we would not want to duplicate that so we would very much like to hear about schemes that already function.

CHRIS FREEMAN
Chairman of Research Committee

Approved by the
Executive and Finance Committee
September 1991

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The following paper is a summary of a special report to Council, based on a paper to the Annual Meeting of the College on 2 July 1991 as part of the Research Unit's presentation of work in progress. The full report will be published in due course in the *British Journal of Psychiatry*.

Auditing the administration of ECT

JOHN PIPPARD, Audit Consultant, Research Unit, Royal College of Psychiatrists

ECT has been valued for over 50 years as an effective treatment for mental illness and especially for depressive illness, and its value has been confirmed by many double-blind comparisons of real and simulated ECT.

Ten years ago I reported to the College on the Survey of ECT in Great Britain which Les Ellam and I had carried out in 1980 (Pippard & Ellam, 1981a). Three years ago (Pippard, 1988) I tried to alert psychiatrists to important research on ECT from America and to the persistence of out-dated habits of practice. It had been hoped that, after the 1981 report, a follow-up survey might have been done within five years to see what had happened, but unfortunately funding could not be found and the project had to be abandoned.

As a Mental Health Act Commissioner and Second Opinion Appointed Doctor, I observed that in some hospitals patients were not getting effective ECT and so were not improving as expected; consultants assumed that because patients had had a course of seizures they had been adequately treated. These patients were being treated with earlier constant current apparatus on too low a setting and their seizures were not therapeutic. It was also clear that the doctors administering the treatment were not being adequately taught to do so. It seemed probable that conditions elsewhere were similarly unsatisfactory and eventually Professor Wing asked me to undertake a limited audit of ECT practice for the Research Unit. We decided to limit this to two NHS Regions and, for convenience in travelling and the widely different communities involved, from rural to inner city, agreed on the North-East Thames and East Anglian Regions. Practice in other Regions is unlikely to differ much. Between February and May 1991 I visited all 35 NHS Hospitals and five private units in the two Regions where ECT is given and talked with the staff involved. I attended a routine treatment session in 29 NHS and two private clinics. The six NHS hospitals in which I could not see ECT give only about 5% of all ECT in the two Regions and the private clinics only treat about six patients a year between them.

In 1989 the College booklet on *The Practical Administration of ECT* was published. This incorporates much of the good advice of the College Guidelines for ECT of 1977, which I used as a standard for the 1981 survey. Using similar criteria I have rated aspects of present practice and compared them with 1981.

The settings in which ECT is done have been greatly improved: nearly all now have separate waiting, treatment and recovery rooms, sometimes of a very high standard, but three large hospitals have not yet achieved this and have to move the equipment from bed to bed, albeit now in cubicled wards, but still with insufficient privacy or shielding from noise. They have been criticised for this by College accreditation teams. In general 80% are excellent or reasonably satisfactory compared with 50% in 1980.

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