'defensive psychiatry' for successful practice of which I offer the following rules.

Rule No. 1 Always protect your own back first.

Rule No. 2 Never, if at all avoidable, accept difficult or dangerous patients – such patients cause problems.

Rule No. 3 Keep your workload and patient count as low as possible – increased workloads give increased scope for errors for which you will be held responsible.

Rule No. 4 Continually document all inter-reaction with patients – seeing patients may be optional but documentation is mandatory.

Rule No. 5 Don't be tempted into any 'risk-taking' with patients – it may help their rehabilitation but won't help you if something goes wrong.

Rule No. 6 Never discharge a detained patient who could under some circumstances, at some time in the future, injure themselves or do something illegal – let the tribunal discharge them for you.

Rule No. 7 If, in spite of following the above six rules rigorously, misfortune befalls, then leave clinical practice and try to get a job in administration.

The above advice is offered 'tongue in cheek'. I wish also, however, to make a serious comment. The increasing political sensitivity of psychiatry, as demonstrated by the Christopher Clunis enquiry, together with a growing emphasis of the role of the psychiatrist as 'policeman' of the mentally ill, as illustrated by the new supervision register, may push psychiatrists towards the type of practice outlined. A psychiatry so dominated by defensive and bureaucratic tactics would no longer be acting in the best interests of its patients. Such practice could result, however, if the political demands now being made upon the psychiatric profession are not accompanied by the provision of the necessary mechanisms and resources for their delivery, as discussed in Jeremy Coid's recent article (*Psychiatric Bulletin*, 1994, **18**, 449–452).

CHRIS GREEN, *St Luke's Hospital, Middlesbrough, Cleveland TS4 3AF*

Improving the quality of psychiatric training

Sir: At the February 1994 meeting of the College, a suggestion was sought on improving the quality of psychiatric training.

To improve training quality, I suggest the introduction of a 'compulsory internal locum' system. Under this system, in a six month period, the trainee will work for another consultant by swapping jobs with one of his colleagues for a designated period of time, the duration of which will be fixed before he starts in that job.

The advantages of this system are manifold. The trainee could pick up specific skills in diagnosis and management from his new consultant, thus widening his training horizons. It would also make the job interesting by providing more variety. There would be closer interaction between trainees and different consultants in the same hospital and an individual trainee would feel less deprived, as he would get the opportunity to work for some of the more 'popular' consultants in addition to his own.

Some of the problems might be a possible lack of continuity in care due to change of junior doctors, confusion among nursing staff at the time of change, and difficulty for trainees engaged in an ongoing research or audit project. None of these problems, however, are insurmountable and can be overcome with a little commitment from all concerned.

The system could be tried out by the Education Sub-Committee of the College in certain training schemes as an experiment before implementing it on a broader scale.

PIYAL SEN, *St Mary's Hospital, London W2 1NY*

Sir: While I welcome Dr Sen's concern about improving the quality and variety of psychiatric training, the proposal for compulsory internal locum is not, I think, a practical or desirable proposal. Indeed the limitations of this proposal Dr Sen himself draws attention to in his third paragraph.

It has been the view of the Court of Electors that continuity of patient care and supervision over a minimum period of six months is not only highly desirable but essential. Discontinuity is likely to be a disadvantage to the trainee, College supervisors and our patients.

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However, innovative College tutors would no doubt find ways of enabling trainees to learn from other experienced teachers organising services – especially for those trainees who may not have a chance to be attached to that particular service during a rotation. This experience could be gained through grand rounds, sessional attachments and attendance by consultants and trainees at case conferences.

JOHN COX, *Dean, Royal College of Psychiatrists*

What about a Trainer's Charter?

Sir: We read with interest the Trainees' Charter (Collegiate Trainees' Committee, 1994). Since the introduction of the Patients' Charter many individuals have expressed the view that charters for health professionals should be introduced. Perhaps the introduction of a Trainer's Charter may act as an eye-opener and pave the road for the development of such charters.

We would propose the following to be included in such a charter:

(a) a certain proportion (e.g. 50%) of time should be spent on service commitment. This would enable a balance to be struck between training and service needs.
(b) the trainee at the offset should inform the trainer of what they intend to learn from the post. This would ensure the time is appropriately directed towards clinical and training commitments.
(c) the trainee would ensure that clinical notes are kept to a high standard.
(d) the trainee would ensure that under supervision discharge summaries and clinical letters are done promptly.
(e) the trainees make arrangements among themselves for adequate cover to be provided for the hospital. This could prove difficult as it is possible for all the trainees to be away on a course on a particular day. In such circumstances, an understandable and flexible approach should be undertaken. This is extremely important in the present economic climate.
(f) the trainer should be mandated to continue their own postgraduate medical education. They should attend all local teaching events and appropriate national courses.
(g) adequate time should be available for the trainer to pursue his or her interests, e.g. research, psychotherapy supervision etc.
(h) the health authority trust should (of course) employ a trainee who is willing to learn.

There are considerable resource implications if these charters are to be exercised successfully. In the current climate, obsessed with market forces, one is left wondering how these opposing obligations can be accommodated. Perhaps the College could take a more active role in helping clinical directors obtain the necessary resources (time, funds, people etc). After all what one is aiming for are high standards of training and psychiatric care (College Bye-laws 11,2).

ROYAL COLLEGE OF PSYCHIATRISTS COLLEGIATE TRAINEES' COMMITTEE (1994) Trainees' Charter, *Psychiatric Bulletin*, **18**, 440.

*P. C. NAIK and N. S. BROWN, *Lynden Resource Centre, Hobs Meadow, Solihull, West Midlands B92 8PW*

*Correspondence

The use of the Mental Health Act in the elderly in another health district

Sir: I applaud Drs Morris & Anderson's pioneering study (*Psychiatric Bulletin*, 1994, **18**, 195–246). A parallel retrospective survey conducted from April 1988 to December 1993 revealed important differences.

The Mental Health Act was used 41 times for 37 admissions in 34 patients. Section 2 was used more frequently (78%) and section 3 less so (28%). Section 5(2) and 136 were used twice, section 4 and 47 once. There was no recorded use of guardianship orders or the National Assistance Act.

The ratio of 'organic' to 'functional' illnesses was the reverse of that reported by Morris & Anderson. In this study 62% suffered dementia and 38% functional illness (half with affective disorders, half with schizophrenia). An important precipitant of admission was self-neglect (75%, severe in 9%) often accompanied by physical or verbal violence and help-resistive behaviour (66%).

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