'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).

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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.

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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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