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Time for a trainees' charter?

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The Patients' Charter was introduced in 1991 (DoH, 1991). Although much maligned at the time and since, it has had positive effects. Much criticism was directed at the lack of resources to implement its generally laudable aims, e.g. reduced waiting times, and it was often dismissed – along with the Citizens' Charter as a whole – as a Tory pre-election stunt. The positive effects were to increase the awareness among patients and health professionals of standards to be aspired to. Personal experience has shown that awareness of the Patients' Charter extends to some of the most psychiatrically disabled patients in Nottingham. All doctors are aware of the Charter and many express regret that a Doctors' Charter of patient responsibilities does not also exist.

Why a Trainees' Charter? The Royal College of Psychiatrists (1987), in its *Inceptors Handbook* laid out the standards that a training rotation and individual jobs should meet. Many trainees are not, however, familiar with the standards set out, I suspect, no rotation could claim to meet all the standards in all the posts on a rotation. A way, therefore, of raising the standards of psychiatric training would be to create a Trainees' Charter which would summarise the *Inceptors Handbook* in an easily digestible form. It would also serve to emphasise the concept of a right to training for junior doctors, who too often in the past have been seen as extra pairs of hands. Thus by raising awareness and strengthening the concept of rights for junior doctors, trainees, especially in their first few jobs, will be in a better position to ask their consultants for what the College says they are entitled. It is important in this process to stress that trainees have a job to do but that they should learn from this job. With these factors in mind, a Trainees' Charter has been drawn up in Nottingham for the Mid-Trent rotation to try to maintain and improve the high standards described previously (Davies & Junaid, 1992). It was presented through the Junior Medical Staff Committee to the Mid-Trent Rotation SHO and Registrar Training Committees. Draft copies were circulated and many constructive suggestions for inclusions and amendments have been received from both juniors and consultants (particularly the Unit and College tutors). It is hoped to publicise the Charter by issuing copies to all consultants and trainees, cover it in the introductory course for new trainees, and display it in poster form in strategic locations such as libraries and lecture theatres. Its implementation can be monitored by the existing Feedback on Jobs Committee, which conducts a six monthly questionnaire survey of juniors' placements covering many of the Charter's points and producing a two yearly report for juniors and the Training Committee.

Trainees' Charter

Clinical training to provide a clinical service by participation in and contribution to that service.

(1) Individual supervision with consultant for one hour per week, not a direct extension of clinical workload.
(2) Unimpeded access to a local training programme of approved study for MRCPsych.
(3) Funded study leave for relevant courses, conferences and meetings, especially College Quarterly meetings and examinations.
(4) One session of research time and appropriate supervision available within the rotation (registrar).
(5) Feedback on progress, positive and negative, and with time to act on it in current placement (suggested three and six monthly).
(6) Regular, meaningful long-term careers advice and guidance independent of current consultant.
(7) All trainees have right of access to College, Personal and Unit tutors over pastoral and training issues.
(8) Supervision and support, appropriate to level of training, with clinical case load, including psychotherapy.
(9) Decent working conditions, hours of duty and accommodation in line with British Medical Association Department of Health recommendations.
(10) Trainee representation on training committees, including participation in allocation meetings.
(11) To be treated with the consideration and respect due to a professional colleague.

The Charter emphasises the clinical nature of psychiatric training, its practical nature and the trainees' responsibilities in providing a service. It also highlights individual education with the keystone of individual supervision with the consultant. In covering the more academic topics of MRCPsych courses, study leave and research, the criticism of fine words and no resources is most keenly felt, with study leave

budgets under increasing pressure from rising course fees and more courses being available. The feedback, career advice, and counselling needs are stressed; trainees need to be advised if they have made the wrong career choice as well as guidance through the obstacles even the best trainees face.

Support with clinical case-load and general conditions of service are covered next. Meaningful involvement with trainees in rotation organisation and allocation committees, as well as being a College requirement, is a good training experience. It also helps improve morale and the smooth running of a rotation by making people feel involved in decisions and therefore more committed to seeing them work.

The final item should be self-evident but many trainees are still bitter about posts they have held. People feel under-valued, left carrying excessive workloads with poor supervision, denied educational opportunities, and feel humiliated and undermined by their consultants. Although not common it is an unpleasant experience which we should do all we can to prevent.

In summary, the Trainees' Charter would seek to raise the standards of psychiatric rotations by increasing awareness of what trainees should receive and encouraging them to ask their trainers for it at an early stage.

It is open to the same criticisms as the Patients' Charter in that it publicises standards without the resources both in money and consultant time to back it up. Unlike the Patients' Charter, it tries to emphasise the rights and responsibilities in the trainer/trainee relationship. Although designed locally for a rotation which meets most of its criteria, I hope it has a national application. Every trainee should ask, "Am I receiving this?" and every trainer, "Am I providing this?".

The views expressed are the responsibility of the author.

Acknowledgement

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Foreign report

Patient advocacy in the Netherlands

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Advocacy for psychiatric patients in the United Kingdom has been established for many years. In 1983 the Mental Health Act set up the Mental Health Act Commission, with powers to safeguard the interests of detained patients; however the commission has no responsibility to safeguard the interests of informal patients. The act sets down guidelines for appeal procedures for detained patients, but appeal procedures are limited in frequency and can be rather formal and intimidating. In addition, appeal procedures deal with major issues such as detainment, but not with the patients day to day management. The influence patients, detained, or informal, have on their day to day management is variable, and depends to an extent on staff attitudes. In the case of an unresolved disagreement between patient and staff, a letter of complaint to the hospital manager is followed up, but some delay in response is hard to avoid. There are various local initiatives, often organised by patient groups, but a structured approach to patients advocacy, apart from the Mental Health Act 1983, does not exist.

In the Netherlands there is an equivalent of the Mental Health Act 1983, which also safeguards the interests of detained patients, but in addition, a separate body, the National Foundation of Patient Advocates offers a structured approach to patient advocacy. In 1986 and 1987 I worked in psychiatry in the Netherlands and frequently came in contact with Patient Advocates (PAs). This report describes