(b) short term in-patient care if not conducted by the community clinician often ends with discharge by a hospital with an unrealistic community aftercare plan
(c) patient mobility as in the Clunis case may invalidate management plans
(d) staff security in a community setting is more of a problem than in hospital. When violence erupts in a community setting be it in a home or a clinic there tends not to be the backup that hospitals enjoy. I learnt this the hard way – fortunately despite a severe beating no permanent damage was done – unlike a social work colleague who was shot.

The issue must be focused on the minority of severely mentally ill who in addition behave violently. I see management of very severely mentally ill non-violent persons in the community as quite achievable. However, asylums are needed for those posing major threats to others. Let's not confuse the two.

CHRIS CANTOR, *76/101 Wickham Terrace, Brisbane, Queensland 4000, Australia*

Requirement of knowledge of local mental health acts in the membership examination

Sir: I would like to congratulate Jeremy Coid on his editorial concerning the Christopher Clunis enquiry (*Psychiatric Bulletin*, 1994, *18*, 449–452). However, almost as an aside, his article does contain one important inaccuracy, which if not corrected could have serious consequences for MRCPsych examination candidates. He says on p.450 "Examination of psychiatrists for membership of the College does not include the Mental Health Act at the present time." This statement is wrong. First, the peoples of the British Isles (the main constituency for the College examination) are served by psychiatrists in four different jurisdictions and there are four mental health acts. The College membership examination part II examines candidates in any of the four acts dependent on the jurisdiction in which the candidate has been working. Candidates can expect to answer questions about the appropriate act for their jurisdiction in either the clinical examination or the oral examination. There is one qualification of this point, and that is that the examiner also has to be familiar with and working in the same jurisdiction as the candidate.

What I believe has misled Dr Coid, and others on occasions, is that the Examination Committee has, for the time being, abandoned any attempt to introduce questions about these four different pieces of legislation into the MCQ, the SAQ, or the essay papers. This is simply due to the difficulty of setting questions which are fair to all candidates and questions which can be marked by all examiners.

There is also a further misunderstanding, from some quarters outside the College, about the responsibility for checking that psychiatrists are familiar with the mental health act they have to operate. This responsibility lies clearly with the Secretary of State for the Mental Health Act (1993), and a health board for the Mental Health (Scotland) Act 1984. It is sometimes wrongly assumed by health authorities in England and Wales, and health boards in Scotland, that doctors who have the MRCPsych qualification are necessarily conversant with the local jurisdiction. It should be obvious that this is not necessarily so; psychiatrists trained in one jurisdiction can, and do, move to another. It follows logically that health authorities and health boards in England, Wales and Scotland, should pursue other methods of scrutiny for this purpose.

I hope this makes a constantly misunderstood situation slightly clearer, and in particular I hope it will prevent any potential candidates for our examination from assuming they do not require knowledge about their local mental health act; they do.

JOHN GUNN, *Deputy Chief Examiner, Royal College of Psychiatrists*

Advice from a paranoid psychiatrist

Sir: As psychiatrists we are becoming increasingly sensitive to the repercussions that may occur should one of our patients seriously injure himself or others. This may be particularly prevalent in forensic psychiatry where the difficulties and dangers associated with forensic patients have the capacity to induce a paranoid and cynical approach in the clinical practitioner. This can lead to a

https://doi.org/10.1192/pb.19.1.54-a Published online by Cambridge University Press

'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 interreaction 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.

https://doi.org/10.1192/pb.19.1.54-a Published online by Cambridge University Press