

Vulnerable patients, safe doctors

Good practice
in our clinical relationships

2nd edition Contents

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- Executive summary
- Principles of good practice in therapeutic relationships
- Factors that affect the quality of the therapeutic relationship
- Factors that strengthen the therapeutic relationship
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Royal College of **Psychiatrists**

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Vulnerable patients, safe doctors

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relationships

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Executive summary

The therapeutic relationship plays a greater part in psychiatric treatment than elsewhere in medicine, and in some modalities it is the only treatment. Maintaining a boundary between personal and professional identities is a key competency for all psychiatrists. This report is a revision of *Vulnerable Patients, Safe Doctors: Good Practice in Our Clinical Relationships* (College Report CR146: Royal College of Psychiatrists, 2007). Since that document was written, the conduct of doctors towards patients has come under even greater scrutiny with a re-examination of regulations governing doctors and the standards expected of them. These standards – for example *Good Medical Practice* (General Medical Council, 2013) and *Good Psychiatric Practice* (Royal College of Psychiatrists, 2009a) – deal with the whole professional role of the doctor, whereas the present report places emphasis on the vulnerability of the patient within the therapeutic relationship, and on the corresponding responsibility of the doctor to the patient. It aims to clarify further the principles for the conduct of good therapeutic relationships and to provide more explicit key guidance points.

This booklet deals with the principles that should underlie any therapeutic relationship, with no focus on specific therapies. The list of principles is not comprehensive, and the principles are not wholly distinct from each other. There will be times when one principle appears to clash with another, as when the autonomy of the patient is at odds with the risk to themselves or others. Similarly, as the relationship between a doctor and a patient is a dynamic one, changing with time and circumstances, the balance of the principles may change with it. The clinician must decide where the balance of the patient's best interests lies.

The principles should be part of daily practice, because all patients are vulnerable, but some situations create more vulnerability than others and in these the clinician should be especially vigilant. Although this document deals particularly with how patients are to be helped and harm to them prevented, it also recognises that the doctor is vulnerable in the therapeutic relationship. The principles and accompanying text contain guidance on how psychological and professional harm to doctors can be prevented and how the reputation of their service can be preserved.

This report is primarily concerned with the principles governing the conduct of doctors towards patients, but it also provides a description of how patient factors and clinical and organisational context can damage or strengthen therapeutic relationships. Thus, it can be read in part as guidance on how employers should treat their staff and how patients should carry out their own responsibilities.

The focus throughout is on the relationship between the doctor and the individual patient. Many of the same principles apply when the doctor is working with a couple or a family. As part of their duty of care, clinicians should be aware of other key documents in this area and be familiar with the main points they make (Appendix).

Sexual boundary violations are at the extreme end of the spectrum of boundary violations and may cause significant psychiatric morbidity. However, the most common boundary violations are non-sexual, and include inappropriate self-disclosure, involving the patient in a dual role (e.g. employing a patient or a patient's relative), speaking aggressively or rudely to patients and financial exploitation. Although sexual violations are less common, they often start with apparently minor boundary violations, such as unjustifiably prolonged sessions, appointments out of working hours, treatment outside the normal place of work when it is not clinically justified, and (in private practice) not charging a fee. Sexual boundary violations between psychiatrists and their patients usually take place in the context of a 'special relationship', to which the patient 'assents' rather than consents; they usually come to light when the relationship ends and the patient then reports the unprofessional relationship. The General Medical Council regards sexual boundary violations by doctors as serious professional misconduct and will normally remove the doctor from the medical register.

Psychiatrists are overrepresented among the doctors referred to the General Medical Council in relation to a number of issues regarding fitness to practise. The aim of this publication is to guide psychiatrists in their everyday practice by encouraging them to adopt the principles underpinning the professional boundaries between patient and clinician. The report is divided into three main sections:

- principles of good practice in therapeutic relationships
- factors affecting the quality of the therapeutic relationship
- factors strengthening the therapeutic relationship.

The clinical vignettes are entirely fictitious, but each contains elements of the main principles presented. They are intended to assist training by stimulating discussion of the issues addressed in the text. Cross-references and links to policy and procedure will enable the psychiatrist and trainee doctor to refer to national and statutory guidance in more depth (Appendix).

KEY RECOMMENDATIONS: AVOIDING BOUNDARY VIOLATIONS IN PSYCHIATRIC PRACTICE

A number of principles regarding the clinical environment and the psychiatrist's conduct contribute to the boundaries of the psychiatric professional encounter; all are the responsibility of the psychiatrist. They fall into the following areas.

The setting (hospital, clinic, partner agency premises, care home or family home)

Treatment or therapy should generally take place in a working environment and not in a practitioner's home. Treatment, therapy or clinical assessment in the patient's home is justified only on clinical grounds, and clinicians should be prepared to justify how and why such work has taken place. However, for some psychiatric specialties, such as old age psychiatry, work in the home – when properly timetabled and organised – is regarded as good practice.

If the practitioner is in private practice and works from home, the work should take place in a designated area, kept apart from the practitioner's ordinary domiciliary arrangements. Treatment or therapy should not generally take place outside the workplace (e.g. in restaurants or places of entertainment), although this can be arranged for treatment reasons, such as exposure work with adults and young people.

Time (usually within agreed service hours)

Treatment or therapy outside in-patient settings should generally take place within working hours of the service (which may vary). If such work is to take place at unusual hours, this should be agreed with a mentor, supervisor or senior colleague and the reasons recorded.

Use of appropriate professional language

Communication with patients should be carried out in non-technical language. Where English is not their first language, doctors should ensure that they are communicating effectively with their patients.

Appropriate professional dress and insignia

Doctors should dress professionally and in such a way that should invoke public confidence and not offend. Clinical and professional standards should be observed at all times.

Supervision

All psychiatrists should have a named supervisor, clinical manager or senior colleague with whom they can discuss their work. For more intensive work, such as formal psychodynamic psychotherapy, or work with patients with complex needs (especially developed or emergent Axis II disorders), supervision is essential and practitioners without an identified supervisor will have to justify why they did not have one, if their work is questioned.

Maintenance of professional boundaries and confidentiality

This includes inappropriate self-disclosure (the most common form of boundary violation) or disclosure of a patient's confidential personal material without

consent. Psychiatrists should make themselves familiar with the guidance on confidentiality produced by the Royal College of Psychiatrists (2010a).

Limited and socially sanctioned physical touch

Sexual relationships with patients or former patients are unethical and unacceptable. Physical touch beyond normal social exchange should be used with caution. The inherent power imbalance between professionals and patients means that touch of any kind may be misinterpreted.

Adherence to clear roles

- Where possible, psychiatrists should avoid treating anyone with whom they have a close personal relationship (Good Medical Practice, 2013).

This is particularly true in cases where the patient is a doctor (e.g. a fellow psychiatrist). Other role conflicts include matters relating to money and property.

- Psychiatrists should avoid being in dual professional roles with patients, for example, being both the responsible clinician and psychotherapist; in the main, this is likely to apply to adult and in-patient services.
- Psychiatrists should not appear as expert witnesses in cases where they know the patient in some other relationship (e.g. as therapist).

However, psychiatrists may act as professional witnesses with the consent of all parties and/or under instruction by the courts (Royal College of Psychiatrists, 2008). There are rare occasions (usually in forensic psychiatry) when the clinician can act as both an expert witness and a professional witness (Royal College of Psychiatrists, 2010a).

Principles of good practice in therapeutic relationships

1 ADHERENCE TO PHYSICAL BOUNDARIES OF SITE AND TIME

The boundaries of therapeutic environment and time are essential measures framing safe therapeutic practice.

CLINICAL VIGNETTE 1: SEEING PATIENTS IN THEIR HOMES

A consultant psychiatrist is concerned about the state of a patient who has not attended a scheduled out-patient clinic. He is aware that the patient will be running out of his medication and decides to 'drop in' unannounced to

the patient's house on his way home after work. He finds the patient at home and leaves the prescription with him. On his way out, he agrees to a quick cup of coffee before setting off. The patient fails to attend the next regular out-patient clinic and the consultant repeats the exercise of visiting him at home. On this occasion, he is invited to join the patient and a neighbour in a beer. He politely refuses and his patient becomes extremely angry, shouting at the doctor as he leaves the premises.

If it is difficult to engage a patient in regular, clinic-based appointments or if they have difficulty in attending (e.g. older adults with comorbid physical illness), it is right to consider innovative ways of maintaining therapeutic contact. Home visits and community clinics, when properly set up and agreed to, are a staple part of community psychiatric work. However, except in certain situations (e.g. under Mental Health Act 1983 procedures), unannounced 'dropping in' on a patient's house is an invasion of privacy, whatever the best intentions of the doctor concerned. Visiting patients on their 'territory', especially unaccompanied, can make a doctor particularly vulnerable; boundaries are often more difficult to maintain than in a formal clinic. The regular therapeutic arrangements are more likely to be disrupted by the patient's expectations after 'special arrangements' have been set up. The likelihood of the doctor engaging in purely social situations grows, with the potential of the blurring of professional boundaries.

CLINICAL VIGNETTE 2: SEEING PATIENTS OUT OF NORMAL CLINICAL HOURS

A male consultant child psychiatrist is contacted by the staff of a residential young people's home about one of his patients, a 15-year-old girl in the care of the local authority. She is extremely upset but will not talk to anyone. The consultant is unable to attend immediately but agrees to visit the home after work. By the time he gets to the home it is 20.00h. The girl has barricaded herself in her room and agrees to let only the consultant in. He sees her on his own in her room. After half an hour he finds that the girl is much more settled. She describes the staff as being too authoritarian and says she has no freedom. On his way out, the consultant has a fleeting conversation with the staff and recommends that the patient be left alone. Several weeks later, the girl accuses the consultant of sexual harassment and abuse while visiting her in the home.

The consultant should not have agreed to carry out such a difficult interview out of 'regular hours' in a setting outside the National Health Service (NHS). Indeed, the lateness of his visit in itself was a transgression of normal visiting/assessment arrangements. The consultant should not have agreed to see his patient on her own and should have insisted that a member of the residential home be present. On leaving the home, the consultant should have sought the views of the residential staff and ensured that the staff, who were acting in loco parentis, had full feedback about the patient's condition and were empowered to manage the situation. Taking notes, keeping

accurate records, prompt and comprehensive exchange of information – in short, good communication between agencies – has a protective and containing effect. The consultant had very little ground on which to defend his position following the patient's complaint and allegations of abuse. The clinician is always responsible for the setting and maintenance of boundaries, even when working with highly dependent patients and even if the patient threatens self-harm.

2 DEVELOPMENT OF SELF-AWARENESS IN THE SERVICE OF PATIENTS

Clinicians should develop self-awareness in order to observe and understand their own feelings and actions within the therapeutic relationship. In so doing, they can disentangle what comes directly from the patient and what aspects of their own attitudes, beliefs and experiences colour their reactions to the patient. They also gain a better understanding of what the therapeutic relationship feels like from the patient's point of view.

Through self-awareness, clinicians learn more about themselves, develop as therapists and become better able to manage themselves in the service of the patient. Although every effort has to be made to resolve a difficult relationship, one result of self-reflection can be an awareness that the therapist is, for various reasons, unsuited to work with a particular patient.

CLINICAL VIGNETTE 3: WHERE SELF-AWARENESS MIGHT HAVE HELPED

A female consultant is aware of her female patient's long-standing marital difficulties, which include domestic violence. The consultant herself has recently been divorced. She has on several occasions addressed the issue of domestic violence during the course of the patient's treatment, and has encouraged her patient to seek independent help from the domestic violence unit run by the local authority. One morning, her patient telephones her to say that she can take it no longer. She asks the consultant for advice. The consultant gives her the name and address of a divorce solicitor, who happens to be a friend, and urges her patient to call the solicitor immediately. She assures her patient that the solicitor is a friend and will deal with the matter urgently.

The consultant psychiatrist had, during her management of the patient's case, correctly advised her to contact the appropriate local agencies, but she fails to do so in the present crisis. Instead, by suggesting a solicitor to her patient, she has become an actor in the difficulties between the patient and her husband, by appearing to take sides. Further, there is a potential conflict of interest, as the recommended solicitor is the psychiatrist's friend. The psychiatrist appears to have primarily been motivated to take such action because of her own circumstances. Understanding her own feelings and actions might have prevented her from taking inappropriate action.

3 RESPECT AND ENCOURAGE THE PATIENT'S AUTONOMY

The clinician is in a particularly powerful position in any relationship with a patient. Patients trust clinicians to handle their power with sensitivity and in the patient's best interests.

Therapy and treatment should work towards empowering patients to take as much control as possible over their problems and to participate fully in decisions about treatment.

Patients are assumed to have capacity to make decisions in their own best interests, and to have the right to consent to treatment or to refuse it, despite the opinion of the clinician. To that end, consent should be sought wherever possible and should be carefully recorded.

The autonomy of patients can be overridden only when they clearly lack capacity. Any treatment proposed must be in the patient's best interests, provided for only as long as is necessary, in the least restrictive way compatible with the patient's safety, and within the law. When the patient is subject to mental health legislation, which may not rest on the patient's lack of capacity, the same principles should apply as far as possible. In determining a patient's best interests, relatives and carers should be consulted whenever practicable.

Particular safeguards should be taken in the care of especially vulnerable groups (such as children, older adults with cognitive impairment and patients with intellectual disabilities) and patients who acquiesce in treatment but do not have capacity to withhold consent. Agreed local procedures and national guidance about these groups (e.g. the Mental Capacity Act 2005 and its Code of Practice: see Appendix) should be strictly adhered to.

4 SHARE UP-TO-DATE KNOWLEDGE AND RECOGNISE YOUR LIMITATIONS

Empowerment relies on patients having information about their condition and its treatment. It is the clinician's duty to share up-to-date knowledge with the patient. Information should be given in a clear and sensitive manner, and repeated as necessary, in private surroundings. It is not generally in patients' best interests for the clinician to withhold knowledge about their condition or to 'invent' certainty where there is none; occasionally, the doctor will have the right to withhold specific information at a specific time in a patient's best interests.

Clinicians must recognise the limits of their knowledge and be willing to refer the patient for a second opinion from another specialist where necessary. They should not stand in the way of the patient's right to a second opinion if it is requested.

Patients are these days much better informed through the internet, media and public health initiatives; and doctors must be prepared to discuss any information brought by the patient with openness and consideration for the patient's views.

Innovative techniques should be used only if there is good evidence of their propriety and effectiveness, and if the patient has been fully prepared and has given informed consent.

5 OBSERVE DOCTOR–PATIENT BOUNDARIES AND AVOID BOUNDARY VIOLATIONS

Any relationship between a doctor and a patient involves a degree of intimacy. It is important to be clear about the boundaries around and within the relationship. However close the doctor and patient may become, the doctor is not, in the fullest sense of the words, the patient’s partner, parent or friend.

CLINICAL VIGNETTE 4: IS A DOCTOR–PATIENT PERSONAL RELATIONSHIP EVER ACCEPTABLE?

An unmarried male consultant psychiatrist moves to a small rural community. He works for the local psychiatric hospital and inherits the case-load of his predecessor. One of his patients is a 28-year-old woman, an accountant, who has suffered recurrent depression. He starts seeing the patient for a course of cognitive–behavioural therapy, a treatment modality hitherto not tried with her. After 12 sessions she appears to have made good progress and is discharged from the out-patient clinic. She remains on antidepressant therapy prescribed by the general practitioner. Some time later, at his neighbour’s Christmas party, he runs into her. Soon they meet at the local sports club and arrange to see each other again. The relationship grows and develops into a sexual one. Several months later, when the consultant tries to break off the relationship, the patient threatens to report him to the General Medical Council. The consultant argues that his therapeutic relationship with the patient was brief and that she was no longer his patient when the affair started.

Sexual relationships with a patient or an ex-patient are never appropriate. Such relationships are almost always unethical, because of the persistence of the unequal power distribution stemming from the original doctor–patient relationship. It is hard for the patient to act outside the confines of the relationship as originally defined. Her very capacity properly to consent is questionable. The doctor believed that his therapeutic intervention was so brief that there was insufficient time to build a strong patient–doctor relationship. The consultant was not aware that he was breaching any code of conduct, given that the relationship between the two started after the patient’s discharge.

6 BE CLEAR ABOUT ROLES

In the relationship with a patient, the doctor may perform many roles – diagnostician, supporter, facilitator, educator, advisor, advocate or therapist. A doctor can move between roles according to the patient’s needs.

Doctors should be clear about which role they are performing at any one time. They should not use professional authority, or a desire to help, to provide non-professional advice without signalling clearly that they are doing so. When called on to perform roles distinct from core professional roles – advising on financial matters, for instance – the possibilities for misunderstanding are greatest and self-awareness becomes most important.

Doctors who are unclear about their role risk confusing the patient and raising unrealistic expectations. Patients may read into the doctor's behaviour a meaning that is harmful to themselves, the doctor and the therapeutic relationship. Patients may invest the doctor with a role transferred from significant figures in their past. The skilled therapist can avoid falling into that role while using awareness of it to further knowledge of the patient.

The well-functioning multidisciplinary team will apportion roles among its members, and thereby provide multiple perspectives for the patient.

CLINICAL VIGNETTE 5: CONFUSION OF ROLES

A consultant child and adolescent psychiatrist is contacted by a surgical colleague at work who is very concerned about his daughter. The consultant is grateful to this surgeon for having managed her son's emergency appendectomy in the previous year. The surgeon's teenage daughter appears to have been depressed for several weeks, is not eating and, on some days, does not even get out of bed. She refuses to see the family doctor or seek professional help. Her parents are worried about her and have wondered whether the child psychiatrist could visit them at home to assess the situation more closely, and recommend a course of treatment. They plead with her not to mention the fact that she is a psychiatrist, but simply to say that she is an acquaintance who happens to have dropped by. The consultant reluctantly agrees to do so. The girl is fetched from her room and the consultant is introduced as a good friend who has lived abroad for a number of years. The consultant finds herself left alone with the child and skilfully engages her in a conversation. She finds out that the daughter is regularly physically chastised by her father. The daughter talks of her parents' endless arguments and her mother's heavy drinking. The psychiatrist listens attentively but feels powerless. In her subsequent conversation with the surgeon, she finds it almost impossible to broach the subject of family influences and fails to address the situation and make the required intervention.

From the information initially given to the consultant, it should have been obvious that the young girl required professional help. From the outset there was a confusion of roles. It was not clear to any of the parties whether the consultant was seeing the young girl as a family acquaintance, friend or therapist. The fiduciary relationship (relationship of trust) is a crucial aspect of the doctor-patient relationship. The basic principle of patient trust was breached by the doctor not declaring her true identity. The first

compromise of appropriate boundaries inevitably leads to further boundary transgressions. The consultant should have refused her colleague's request by saying that she understood that the surgeon may have thought this a helpful intervention but that it left her feeling uncomfortable. She should have warned him that a home visit under the suggested circumstances would render her just as helpless as the parents. Ultimately, the consultant failed her duty of care towards the patient and was in breach of safeguarding procedures.

7 BE AWARE OF YOUR VALUES BUT DO NOT SEEK TO IMPOSE THEM ON THE PATIENT

Doctors may adopt values and attitudes from their own personal and professional background which are different from the patient's but, through self-awareness, the good clinician will be able to identify them, facilitating work with the patient's individual, family and ethnic culture. The doctor should be sensitive to the possibility that different interpretations may be placed on even the most routine of medical practices. Misunderstanding may be avoided if experienced interpreters are sought when language is a problem.

Although it is no part of a therapist's role to persuade patients to conform to his or her values, it may sometimes be the doctor's duty to confront patients with the consequences of their actions if they harm others. Such confrontation may have to be carefully weighed against harm to the patient's medical interests through a damaged therapeutic relationship.

In rare instances, the views of particular patients or those around them may be so extreme as to be commonly regarded as offensive. The doctor may need to follow local or legal procedures to protect victims from the harm these views may cause. Doctors need to be aware of the values they may unwittingly provide (the Equality Act 2010).

8 RESPECT PRIVACY AND OBSERVE CONSENT TO DISCLOSURE

For trust to develop between patient and doctor there must be privacy in their relationship. The right to a private life is detailed in Article 8 of the Human Rights Act 1998; and doctors have an ethical and legal duty to keep patient information confidential (General Medical Council, 2009; Royal College of Psychiatrists, 2010a). The relationship between patient and doctor is one of 'fidelity' or 'trust', and most patients tacitly believe that confidential information will not be further disclosed or used without their awareness and consent.

Nevertheless, the doctor's duty of confidentiality is not absolute and may conflict with other ethical and professional duties. Disclosure should normally be only with the consent of the competent patient, but there are circumstances set out by the law or in the public interest in which patient confidentiality is overridden by a duty to disclose. In such circumstances, uses or disclosures may be made, but only the minimum necessary information shared in order to

address the emergency. The sharing of patient information can be considered for three situations:

- where it is to help meet the patient's healthcare needs
- for other healthcare purposes (e.g. commissioning of services)
- for purposes outside healthcare (e.g. public safety).

Each situation to some extent requires different considerations beyond the general ones for consent. For detail, see *Good Psychiatric Practice: Confidentiality and Information Sharing* (Royal College of Psychiatrists, 2010a).

9 MANAGE RISK IN THE INTERESTS OF THE PATIENT

Patients with mental disorders may present a risk of harm to themselves or other people. Psychiatrists are expected to manage that risk (Royal College of Psychiatrists, 2010b,c) and balance a duty to support recovery and autonomy with a duty to prevent serious harm.

Risk management does not mean avoiding all risks of any harm; it may mean taking considered risks. Strict adherence to guidelines, for fear of risk, should not be allowed to stifle responsible, innovative practice or the patient's choice of alternative therapeutic solutions for a particular problem.

Risky behaviour may warrant the temporary takeover of control by the doctor to prevent harm to the patient or to others. This is the ethical and legal basis of our Mental Health Act. When invoking the Act, psychiatrists are expected to be able to show that its use will be directed towards demonstrable benefit to the patient. The Act requires doctors to be able to show that there is an appropriate treatment for those detained, and that detention is not solely for containment of risk.

10 DEVELOP A CONTRACT OF MUTUAL RESPECT

Therapeutic relationships are founded on mutual respect. Best results from therapy arise when there is a matching of expectations and the patient feels that their doctor or therapist understands and empathises with them. Respect and confidence are promoted when the capabilities of the therapist match the expectations of the patient. If the expectations of the patient exceed the capabilities of the therapist, the result could be a negative 'contract' of blame and defensiveness, and could cause harm to the patient.

Therapy should not be delivered by therapists who are not properly trained to deliver it. The aim of therapy is to effect change; but change cannot be assumed. The process of change can be difficult and painful, and it is wise to warn patients that therapy is not always comfortable.

Respect is developed over the stages of a relationship – the building up of trust, cooperative working on the problem and a healthy separation. Such a

process cannot be rushed. Except in an emergency, the doctor should proceed at a speed the patient can manage towards targets the patient can achieve.

Reasonable compromises may have to be reached between the clashing expectations of the clinical team, the patient and the patient's family or carers.

The therapeutic alliance relies on trust. Although trust is a cornerstone of therapy, it is good practice for records to be kept of therapy sessions, which should be full enough to reflect the sessions with accuracy (see 'Records', p. 28). However, no amount of clinical record-keeping is a substitute for good clinical practice.

Factors that affect the quality of the therapeutic relationship

1 PATIENT FACTORS

(a) Decreased mental capacity

Although we should always start from the position that patients have full capacity to make their own decisions, all mental disorders can impair the capacity to understand and make decisions in one's own best interests. It is part of a psychiatrist's role to be able to assess capacity, and such assessments need to be carried out thoughtfully (Department for Constitutional Affairs, 2007; Scottish Government, 2007; Brindle *et al*, 2013; Jacob *et al*, 2013).

Psychiatrists need to keep themselves up to date with ethical and legal guidance on working with patients who lack capacity. This can be complex in cases where patients have long-term incapacity, but appear to be compliant. Assent is not the same as consent.

(b) Vulnerability and disempowerment

Patients may feel powerless and vulnerable because of their illness, the relationship with the doctor, the services they have grown dependent on, the housing or benefits system and unemployment. They may feel especially vulnerable if in extreme distress: physical or emotional, chronic or acute. Some patients, whose illness does not formally reduce their capacity, have such rigid personality problems that they cannot fully understand a situation or make use of that understanding.

All mental disorders can leave patients feeling vulnerable at times, especially those who are detained and/or forcibly medicated. Patients seeking therapy because of unresolved childhood distress may be particularly vulnerable in therapeutic encounters.

Patients who have been subject to physical, emotional or sexual abuse may distort the meaning of the doctor's behaviour if aspects of the therapeutic encounter unwittingly echo the patient's previous traumatic experiences. Doctors must consider possible interpretations of their behaviour from the patient's point of view and be aware that their therapeutic intentions may be misinterpreted.

It is the duty of all psychiatrists to respect vulnerability in patients and to refrain from exploiting any power differential.

(c) Minority groups

Patients from ethnic or cultural minorities (immigrant or indigenous), sexual minority groups, travellers, the homeless and ex-prisoners may feel themselves vulnerable in the world of the majority (Royal College of Psychiatrists, 2009b, 2010d). Such individuals may feel generally alienated by their surroundings and react with understandable suspicion, open hostility or over-compliance. Further, some of the 'routine' practices of medicine (such as physical or mental state examination) may be specifically offensive. The onus lies on the doctor to understand cultural sensitivities and respect them – not on the patient to fit in with the prevailing ethos.

CLINICAL VIGNETTE 6: CULTURAL INFLUENCES

A 42-year-old woman arrives for an appointment at the out-patient clinic. She is a refugee from a war-torn country. She was referred by her general practitioner, who suspected psychological trauma. She does not speak English. The psychiatrist had been warned of this by the general practitioner, but for the second time running the interpreter fails to turn up for the appointment. The psychiatrist decides to go ahead with the assessment, as the woman's 14-year-old son has accompanied her to the clinic and he speaks fairly good English. As the psychiatrist starts taking a more detailed history, the patient becomes visibly upset and starts crying. There is a long and protracted conversation between mother and son, very little of which is translated. When the psychiatrist asks the son to tell her what has upset his mother, the mother silences the boy. A further angry exchange takes place between mother and son, after which the son quickly tells the psychiatrist that his mother is regularly physically abused by the father at home. He refers to the bruises on both her arms, which are presently covered by her clothing. The mother remains unaware that this information has been conveyed. The son pleads with the psychiatrist not to give him away, speaks to his mother and the two get up and leave the clinic.

Good practice demands that an interpreter be present at an interview if the patient does not speak the doctor's language, as using family members or friends to interpret can lead to a number of difficulties: interpreting, in addition to being dependent on a good command of the languages being translated, also requires a neutral interpreter. In this case, the son has

become involved in the therapeutic interview and has altered its dynamics. The son used the opportunity to make a disclosure about family life and domestic violence. It is not clear whether the information gleaned is the son's or the mother's. As a result, the clinician may not be able to use it. The therapeutic boundaries have been transgressed (as a result of the improvised and informal structure of the psychiatric assessment) and the psychiatrist may not be able to make referrals or contacts with statutory agencies with a view to remedial action. The psychiatrist may now not be able to treat this patient.

2 THERAPIST FACTORS

(a) Professional training, experience and support

All doctors may be tempted to perform beyond their level of competence because of lack of training, experience or support. Junior doctors may lack the experience to cope with a difficult situation or have insufficient supervision from their seniors to guide them. Senior doctors may act beyond their specialist knowledge or in isolation from peer-group advice, support or appropriate continuing professional development. Regular supervision and appraisal enhance good practice. Feedback provided by patients is highly informative and is at the core of the process of revalidation.

CLINICAL VIGNETTE 7: CONFUSION OF ROLES AND WORKING IN SECRECY AND ISOLATION

A male consultant in general psychiatry is persuaded to see a troubled female nurse in the same team 'as a friend'. They meet after hours in an empty out-patient department to avoid any embarrassment to the nurse. She asks that no official notes are kept, for fear that colleagues may see them, as it would be a 'black mark' on her file in the eyes of management. The consultant, for the same reason, speaks to no one about the arrangement. At the end of the first meeting, the nurse is in tears and the consultant gives her a friendly hug – during which a cleaner barges into the room. The consultant takes the nurse home in his car because he considers she is too distressed to drive. He stays for a cup of tea and tries to comfort her further by telling her about his own marital separation and his subsequent recovery. In the following weeks, the nurse becomes increasingly demanding and sends a number of passionate letters. When the consultant tries to distance himself, she threatens to expose his 'seduction' of her, citing evidence from the cleaner.

A confusion of roles can arise between two clinicians if one of them becomes the other's patient. Is the consultant seeing the nurse as a friend, as a colleague or as a therapist? From the information given, it should have been clear from the outset that the nurse required professional help, which it would be inappropriate for the consultant to offer, knowing her in his capacity as a friend and colleague. Once this confusion had occurred,

the danger was magnified by the circumstances in which the nurse was seen – a deserted out-patient clinic, with no notes taken and no objective advice available to the consultant. A professional relationship could have preserved confidentiality without a cloak of secrecy. This was compounded by a further violation of boundaries – taking the nurse home, the cup of tea and comfort, the consultant's inappropriate self-disclosures. What matters is the interpretation the nurse would put on his actions, not the innocence of the consultant's intentions.

(b) Management

The doctor's position and the patient's confidence can be undermined if lines of clinical responsibility are unclear or confused with service management requirements. Doctors may fail to act in the patient's best interests under the pressure of unrealistic expectations placed on them by commissioners of services or service managers. This may harm the patient, and can be threatening to the doctor if service shortcomings are confused with the individual doctor's competence.

(c) Personal factors

The doctor's unresolved personal problems can 'leak' into the therapeutic consultation, especially where themes in the consultation resonate with the doctor's predicament. Here, often unwittingly, doctors may be unable to view the patient's needs objectively or may use the consultation to meet their own needs (e.g. by excessive self-disclosure).

Doctors may develop a psychiatric illness that interferes with their ability to practise satisfactorily. Or, while short of frank illness, a doctor may have personality problems; these can range from habitual unhelpful attitudes (such as an over-comforting or over-controlling personal style) to rigid personality disorders. The opposite situation, in which the style of the doctor (e.g. as 'saviour') fits only too well with the style of the patient (e.g. as 'victim'), may be equally unproductive. Perfectionism and an exaggerated sense of responsibility are encouraged in medical education and the work environment but can often be detrimental to both doctor and patient if left unchecked.

Many doctors have personal values derived from their upbringing or life experiences that may make them unsuitable to conduct therapy with particular individuals or groups of patients with different values. A doctor's ethnic or cultural background may affect their interpretation of a patient's symptoms or way of life, and their manner of relating to patients.

CLINICAL VIGNETTE 8: THE CONSULTANT'S PERSONAL SITUATION

A male patient tells a male consultant psychiatrist that his wife has left him. The consultant is himself a divorcee. He tells the patient of his own experience and of the depression that followed divorce. He recalls his period of heavy

drinking and promiscuous behaviour. The patient sympathises. In a mutual attempt to cheer each other up, the consultant and patient jokingly agree to 'hit the town' one of these days.

Psychiatrists and clinicians of course practise reflectively and with the knowledge of what will often be common experience, but they should ensure that they do not disclose personal information. The sharing of personal information may be experienced as intrusive by the patient and, however minimal, is likely to lead to further boundary violations. Personal information about family, be they adults or children, should not be shared with patients (e.g. 'my son's room is just as untidy' or 'my father died last year and I understand how you feel'). Clinicians who are vulnerable, for example as a consequence of personal loss or substance misuse, may find themselves making personal disclosures to remedy their own loneliness. Disclosure of personal information is always unnecessary and introduces a false mutuality into the doctor-patient relationship.

3 FACILITIES AND ORGANISATIONAL FACTORS

The vulnerability of both patient and doctor is increased in certain situations, such as deserted out-patient clinics after hours, hospital settings during quiet periods (e.g. nights and weekends), settings ill designed for psychiatric consultation (e.g. wards in district general hospitals, accident and emergency departments, police stations, public spaces), private consulting rooms, some community health facilities and home visits.

All of these are further influenced by the availability of advice from other people, geographical isolation, the time of day at which the consultation takes place and the quality of the facilities.

4 RISKS OF TREATMENT FOR THE PATIENT

All psychiatric treatments carry risks for the patients. Doctors need to be especially aware of the dangers involved and seek to minimise them with advice, supervision and explicit consent. Dangers include unwanted side-effects and iatrogenic harm (e.g. from medication), and the dangers of poor technique in the psychological therapies.

Psychological therapies may be consented to and then experienced as intrusive or coercive. Therapies may be well performed but abruptly ended because of resource or staffing problems.

All psychiatric treatments need to be started carefully, monitored closely and reviewed regularly with the patient. Psychological therapies should be supervised by a senior or peer, and reports provided to the patient on a regular basis. Physical therapies need to be reviewed regularly, especially in relation to their effect on physical health.

No therapy should be carried out by untrained staff except as training cases under supervision; and no innovative therapy should be carried out except as part of a care plan and with evidence of informed consent.

5 CONFLICTING SITUATIONS

Conflicting situations underlie a range of topics already discussed. There may be a conflict of roles: doctors may be confused about what role is most appropriate in a therapeutic situation or may mistakenly attempt to take on several conflicting roles simultaneously. There may be a specific conflict of interests, as when a doctor attempts therapy with a member of their family or someone else they know personally. There may be conflicts with external agencies, service managers and colleagues, or within malfunctioning teams, that place the doctor under stress.

The interface between private and NHS work is a source of potential conflicts.

Finally, a doctor may be caught between conflicting principles – when, for example, within the confidence of a therapeutic relationship they receive worrying information about a third party that must be acted on.

CLINICAL VIGNETTE 9: A POTENTIAL CONFLICT OF FINANCIAL INTEREST

A consultant in the psychiatry of old age has a husband in the antiques and valuation trade. A patient whose own husband died recently gives her frequent unsolicited gifts from a collection of porcelain and pictures. The consultant's husband tells her these are valuable and it is clear that the patient has no real idea of their worth. The patient is increasingly unable to cope in her own home and the consultant strongly recommends admission to a nursing home. The patient asks the consultant for advice about selling the contents of the house, and the consultant involves her husband in the valuation and clearance sale. A distant relative of the patient complains when he spots articles that he remembers from childhood visits for sale in the shop belonging to the consultant's husband.

The first issue here is the acceptance of gifts. While it may be churlish for a doctor to refuse all 'thank you' presents from patients, however small, the consultant should have known that it was inappropriate to accept frequent gifts of high value from an elderly person who had no idea of their worth and whose judgement may well have been compromised by her recent bereavement; it may also conflict with the policy of the organisation in which she works.

The second issue is whether this was advice she was qualified to give. She might advise that it was in the interests of the patient's mental health to dispose of the property, but she is not qualified (except as much as any lay person is qualified) to advise on the financial grounds for disposing of them.

The third issue is the conflict of interest. It was totally unethical for the consultant to involve her own husband while advising her patient. By putting business her husband's way, which will likely benefit her, she cannot be seen to be giving advice in her patient's best interests, regardless of the grounds. The relatives would be justified in their complaint.

CLINICAL VIGNETTE 10: A POTENTIAL CONFLICT OF INTEREST IN FORENSIC PRACTICE

A psychiatrist is instructed by the court to prepare a report on a defendant who is awaiting sentence for a criminal offence. The instruction includes an assessment of 'dangerousness'.

Whether the instruction is made by the court, defence or prosecution, the duty of the psychiatrist is to assist the court by providing a report, as either a professional or an expert witness. On occasion, such a request may produce a potential conflict of interest for the psychiatrist between serving the court and protecting the defendant's mental health needs. The psychiatrist should explain to the defendant their role and purpose at the beginning of the interview, and obtain the defendant's consent to continue the interview on the basis of this explanation. The psychiatrist, in addressing the mental health needs of the defendant, should restrict their report to providing an opinion as to whether the defendant has a mental disorder and, if so, to recommending treatment, which should include an opinion on whether that treatment should be delivered on an in-patient or out-patient basis.

The psychiatrist should not make any recommendations for sentencing other than those described above. In addressing 'dangerousness', they should provide a risk assessment based on the risk factors derived from an appraisal of the facts of the case and their opinion on the defendant's mental condition. The risk assessment should cover the defendant's likely response to treatment, so that it contains a conditional element.

CLINICAL VIGNETTE 11: THE CONFLICTING INTERFACE BETWEEN PRIVATE PRACTICE AND NHS PRACTICE

A 35-year-old man with a history of depression and borderline personality disorder is referred to a specialty psychotherapy service. Following an initial assessment, he successfully engages in a course of treatment over a period of 1 year. A reorganisation of services in the department where he is being seen results in a reduction of staff and planned termination of his treatment, as a cap is put on the overall length of treatment provided to all patients. His therapist considers that the patient has made considerable gains in his treatment but that he would benefit from a period of consolidation. She suggests that seeing the patient privately, and the patient accepts.

The interface between private and NHS work in both directions is a source of potential conflict. Referrals from the private sector to the NHS and *vice*

versa are not always appropriate and any such transfer of patients needs to be carefully scrutinised, particularly if the receiving and referring doctor is the same person.

Factors that strengthen the therapeutic relationship

1 PATIENT EMPOWERMENT

(a) *'Knowledge is power'*

Patients should be fully informed about the proposed assessment and treatment processes. Allowance must be made for distress, anxiety and acute disturbance of their mental state, as these may make it difficult for them to absorb information. Patients may not remember being given information, or their recollections may be distorted.

Consultations should facilitate the exchange of information. Patients' views and wishes about their treatment need to be established. The psychiatrist should clarify their own role and what they expect to provide at each stage of assessment and treatment.

Sensitivity to the patient's sociocultural context (including language) and ability to understand it will aid communication.

Written material that describes the assessment and treatment processes, explains particular diagnostic categories and gives information about medication and its side-effects will facilitate patient empowerment.

Many patients access information on the internet. Clinicians need to be open to this resource and ensure that they are themselves fully informed.

(b) *Choice*

Clinicians should explain the choices available for the patient's treatment, i.e. where it is to take place (e.g. on an in-patient, day patient or out-patient ward), and what treatment is to be offered, by whom and for how long.

If there is effectively no choice because of limitation of resources and personnel, or if the clinician feels that there is a single treatment of choice, this also needs to be discussed and the patient's resistance or disappointment acknowledged.

If the patient, or their family, want an alternative treatment, steps need to be taken to help them to access this – provided that, from the clinician's viewpoint, it will not endanger the patient. Referral back to the patient's general practitioner or to a colleague may be appropriate.

If a patient may be at risk from the choice they or their family wish to make regarding treatment, the clinician may need recourse to the legal framework (e.g. the Mental Health Act 1983, as amended in 2007, or the Children Act 2004).

(c) Patient responsibility

Patients are not always aware of what is expected of them in the therapeutic process. They should be helped to take responsibility for attending appointments, time-keeping and their behaviour in out-patient and in-patient settings. The limits of acceptable conduct should be made clear regarding the use of alcohol and drugs and abusive behaviour towards staff or other patients. Sanctions should be stated where appropriate, with recourse to statutory agencies and the police when needed.

Therapy should encourage patient autonomy wherever safely possible. The more patients can take charge of their own lives, the less vulnerable they are.

(d) Contracts

Consent to treatment may be given verbally but should be recorded.

A written contract may be drawn up, for example for participation in a specific therapeutic programme. Written agreements can increase motivation and facilitate monitoring of outcomes.

Written consent must be obtained in certain circumstances (e.g. for video-recording and for participation in research and teaching events).

(e) Advocacy, carers, family support, interpreters and chaperones

The presence of carers or friends in the consulting room should not preclude, or be a substitute for, the employment of official interpreters when this is indicated. It will not always be obvious to the psychiatrist that the patient does not understand the questions put to them. Equally, the patient may give the answers that they think the doctor expects from them. It is sometimes only the carer who will command an accurate picture of the patient's circumstances, including information about their treatment and medication. The patient's entitlement to support in the session through the involvement of family members, carers, friends or an advocate should be made explicit. This should include clearly advertised written information in waiting rooms about the availability of trained advocates, interpreters and other support services. Patients must consent to the presence of others unless there are good clinical reasons to disregard their wishes. The benefits of including others have to be balanced against the risk to the confidentiality between clinician and patient.

Co-working with other team members or with workers from other services who have a prior relationship with the patient may also support the patient and have a containing and protective effect. If it is not considered helpful to have several

clinicians in the room with the patient, a one-way screen allowing observation and intervention can be considered. This should be properly explained to the patient beforehand and consent for its use obtained.

Chaperones may be needed for work with vulnerable patients of the opposite gender, particularly if physical examination of any sort is to be carried out.

(f) Second opinions

When patients or their families express doubt about a diagnosis or treatment options and seek another opinion, clinicians should be open to this and facilitate it. A patient's right to another opinion should be confirmed in a non-defensive manner.

The doctor should always consider recommending to the patient that a second opinion be sought when diagnostic or therapeutic progress is lacking.

Patients should be reassured that they will not be discriminated against in their subsequent care if they question a doctor's judgement or offer of treatment.

Repeated requests for change of treatment plan or alternative options, however, may be part of the patient's pathology. Resisting this may be in the patient's best interests.

(g) Complaints procedures

Every clinic should make its complaints procedure accessible to patients and carers, and clinicians should be familiar with it. However, timely discussions with patients will usually prevent formal complaints from being made and help preserve the therapeutic relationship.

Healthcare trusts should have a clearly advertised system for patients and carers to enquire confidentially about the standards of conduct expected of doctors in therapeutic relationships, and guidelines about how they may raise concerns if they suspect that abuse has taken place.

Formal procedures should be independent of the doctor or service concerned, conducted, for example, by a professional membership organisation.

2 DOCTOR EMPOWERMENT

(a) Good-quality care and case-load management

Psychiatrists should be able to demonstrate the continued delivery of good-quality care through daily practice, supervision and appraisal.

Doctors should have a realistic workload in terms of numbers, case-mix and emergency/urgent work. Case management, which is the management and prioritisation of the doctor's workload, is a skill that each clinician needs help to acquire from a mentor, manager or senior colleague.

Increases in workload when there is a staff shortage arising from retirement, sickness or failures in recruitment must be recognised. Responsibility for prioritising work under these circumstances should be shared by the managers of the service, probably in the job-planning process.

Clinicians should have access to the facilities they need for the safe care of patients.

(b) Supervision

A regular opportunity for discussion of cases with an experienced supervisor – individually or with a group of peers – improves and safeguards clinical practice.

If a clinician recognises that a particular situation is potentially problematic, they should seek specific supervision for the case.

(c) Professional development

Training and understanding protect clinicians from vulnerability to doubt in clinical situations. Continuing professional development is essential in maintaining their confidence in their work. Opportunities for learning new techniques and knowledge must be available. These should include time for private study as well as attendance at local and national courses and conferences.

Sensitively undertaken personal appraisal and monitoring will raise awareness of gaps in knowledge and areas of practice where competence needs to be improved, leading to the creation of an action plan for further training. Such action plans should be regularly reviewed in supportive, peer-group settings.

(d) The multidisciplinary team

The team offers a range of knowledge and skills for the care of the patient. This is particularly important in complex and challenging cases. Each clinician is potentially supported by other members of the team, but the sharing of responsibility for patient care needs to be balanced by clarity of roles in joint management and clear allocation of ultimate responsibility for each patient.

The team approach provides multiple perspectives during case discussions and enables joint planning to take place. It offers opportunities for co-working, which is therapeutic and educational for clinicians.

Unhelpful team dynamics regarding power, rivalry and responsibility can sometimes develop. These interfere with patient care and need to be resolved. Opportunities for examination of team dynamics with an outside facilitator may reduce such risks.

(e) Quality assurance

Employing organisations should encourage clinicians to participate fully in the organisation's quality assurance systems and support them in their individual professional development. Sharing data on benchmarking, service comparisons (both within and outside the organisation), and patient surveys and outcomes helps clinicians appraise their own performance and that of the services in which they work. Although doctors must use resources responsibly, deficits that are clearly due to lack of resources are the final responsibility of managers and commissioners.

A strong user/carer voice in the planning and review of services is essential and will reinforce and enrich rather than undermine the role of the clinician.

(f) Personal support and development

Psychiatric practice intimately affects, and is affected by, the therapist's personal and family life.

Confidence to deal with difficult therapeutic encounters is enhanced by discussion with colleagues.

Self-awareness increases a therapist's competence to deal with areas of personal conflict and vulnerability that would otherwise impinge on their work with patients.

Experience of mentoring and coaching, personal therapy, sensitivity groups, group relations events and other forms of experiential learning can make clinicians less vulnerable in the clinical situation.

3 ORGANISATIONAL AND PROFESSIONAL ISSUES

(a) Resources

Safe practice depends on having adequate resources to do the work. These include appropriate facilities (e.g. beds), adequate time (e.g. for consultations with patients and their carers, for supervision and case planning, and for education and training) and sufficient colleagues in the team (e.g. to consult with and to provide cover for leave and for continuing professional development). Standards for the delivery of care need to be regularly agreed with service managers. Comprehensive appraisal and revalidation processes involving the managers will facilitate the provision of adequate resources for good standards and safe practice.

(b) Records

Records protect the doctor and the patient. They should include: accurate, contemporaneous session notes, records of case planning and conferences,

letters to the general practitioner and other professionals, and careful logging of critical incidents and risk assessments. Patient records can be written or electronic, and should be subject to regular supervision and audit.

In the records, careful distinction should be made between observations, what was said by the patient and doctor, opinion, and recommendation. Serious differences of opinion between team members should also be recorded.

When writing notes, doctors should bear in mind that the patient has the right to read them. Patients also have the right to receive a copy of any correspondence about them. Pejorative and value-laden statements should not be used.

Where difficult decisions have to be made, full details of the decision-making process should be given.

Records, however carefully kept, can never be a substitute for good verbal communication between professionals and between doctor and patient.

CLINICAL VIGNETTE 12: ABSENCE OF CLINICAL RECORDS

An adult consultant psychiatrist practising privately is asked to see a famous actor by a mutual friend. There is no formal referral letter (e.g. from a general practitioner). The consultant meets with the actor, who insists that no notes be made or records kept of the treatment, owing to potential media interest. The patient refuses to allow the consultant to seek information from any relatives. Indeed, the patient insists that these conditions are agreed to before he proceeds with the assessment and any treatment. The consultant agrees. The consultant does not envisage the therapy lasting long and estimates that a few sessions of supportive psychotherapy will resolve the problem. However, new problems come to the fore and the course of therapy is prolonged. After 8 months, the patient is found dead. There is evidence of substance misuse. There is intense media interest. The consultant is asked to provide a professional witness report for the coroner's court. During the inquest the family dispute factual information contained in the report. The consultant is advised that he will, of course, be expected to support his evidence with his recorded or written documentation.

Full records protect both the doctor and the patient. This ordinarily includes notes taken during or immediately after a session, records of case planning and conferences, letters to the general practitioner and any other agencies, and logging of critical incidents and risk assessment. A formal letter of referral should always be sought. In the absence of a formal referral, it is even more important to obtain independent information. In this scenario, the consultant has acted outside the normal parameters of professional behaviour by failing to observe guidelines on good medical practice. It is unlikely that he will be able to ward off any potential criticism of his management of the case and he will be found negligent in carrying out his clinical duties.

CASE VIGNETTE 13: ARE EMAILS CLINICAL RECORDS?

A consultant child and adolescent psychiatrist receives an email from a patient's mother on the day after the first assessment of a 13-year-old girl. It is a chatty message where the mother states how much the family enjoyed the meeting. The consultant thanks her. A week later, the mother writes again, asking when the cognitive-behavioural therapy (CBT) sessions will start. The consultant writes back, helpfully informing her of the start date. The correspondence continues amicably until one day the mother writes complaining about the CBT sessions. The consultant stops writing back. The mother's emails persist. The consultant stops opening the emails and deletes them before she reads them. Three weeks later the patient takes an overdose of tablets. The mother lodges a formal complaint against the consultant, stating that she had informed the consultant by email of her daughter's sudden deterioration in mental state and had had no reply.

The consultant in this case should have explained to the patient's mother at the outset that communicating by internet is unsafe and lacks confidentiality and that any continued correspondence by email would have to be taken with that risk in mind. If the patient's mother agreed to this form of communication, despite the confidentiality risks, clear agreements should have been reached about the form and nature of the correspondence. The consultant should have warned the mother that there would be no guarantee that emails would be read regularly or in the consultant's absence. Clear communication lines via the clinic administrator should have been established for emergencies. The consultant should also have taken up the mother's complaint about her daughter's CBT through the appropriate channels at an early stage, rather than ignoring it.

(c) Formal frameworks for professional conduct

All doctors are bound by the civil and criminal laws of the country and by guidance given by the General Medical Council, which acts as the professional regulator for medical practitioners. It is the doctor's duty to be registered with the General Medical Council and to have fulfilled their professional obligations in terms of training, registration and revalidation.

Psychiatrists are also expected to adhere to the professional codes of conduct laid down by the General Medical Council (2013) and the Royal College of Psychiatrists (2010a).

Locally agreed procedures (e.g. for safeguarding of children) and trust policies provide guidance for complex situations.

Participation in appraisal and revalidation processes will establish confidence in the doctor's practice.

Doctors should be familiar with national and local guidelines for specific practice and follow them where appropriate.

(d) Audit and research

Audit allows clinicians to compare service or individual practice against local or nationally agreed standards, and is a tool for reflection, improvement and promoting change. Audit might examine whether practice meets the standards for the therapeutic relationship described in this report.

Evidence-based practice, using local or published research, helps develop and promote safe and effective treatment techniques.

(e) Whistle-blowing

Each clinician has a responsibility to draw attention to the conduct or practice of a colleague if they believe it to be unsafe, incompetent or unethical. There should be clear routes for raising concerns with those who can take action. Managers should create a climate in which clinicians do not feel victimised if they exercise this responsibility.

CLINICAL VIGNETTE 14: WHISTLE-BLOWING

A junior trainee on placement in a service for adults with intellectual disability is concerned about aspects of her consultant's style of working. The consultant also happens to be the clinical director of the service. The junior doctor has noted his patronising manner and sarcastic attitude. She has heard him comment on his patients' physical appearance and dress, in a very intrusive manner, for example calling them 'fatty' and 'slow-coach'. During ward rounds he has made jokes at his patients' expense and frequently talks about them in the third person. She has also seen him shouting at staff in front of patients. Her consultant's demeanour and clinical practice are making the junior increasingly uncomfortable. Following an incident when he used a dismissive racial epithet about a patient as he turned away, the junior sought advice from another consultant. She was told to keep her head down, finish her clinical placement and focus on getting a good reference if she wanted to continue with her training. The junior doctor was reminded that the consultant in question was well respected and influential in the psychiatric establishment.

Junior doctors have a responsibility to raise concerns about their seniors if they observe something that they consider to be unacceptable clinical practice. Routes for raising concerns should be made clear during the induction process and the training of any new member of a clinical department. Junior doctors, or any other mental health staff, should be assured of protection from adverse consequence if they have a justified complaint or reasonable grounds for making what turns out to be an unjustified complaint. The regulations governing the reporting of possible abuse of patients by staff within an institution should be clear. Those whose guidance is sought in the making of a complaint should act strictly within the rules laid down for considering such a matter, even if, in the end, the doctor seeking guidance takes the complaint no further.

Appendix: Key legislative and professional guidance

LEGISLATION AND LEGISLATIVE GUIDANCE

Children Act 2004 (www.legislation.gov.uk/ukpga/2004/31/contents).

Disability Discrimination Act 1995 (www.legislation.gov.uk/ukpga/1995/50/contents).

Equality Act 2010 (www.legislation.gov.uk/ukpga/2010/15/contents).

Human Rights Act 1998 (www.legislation.gov.uk/ukpga/1998/42/contents).

Mental Capacity Act 2005 (www.legislation.gov.uk/ukpga/2005/9/contents).

United Nations Convention on the Rights of the Child, 1990 (<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>).

Adults with Incapacity (Scotland) Act 2000 Code of Practice: For Practitioners Authorised to Carry Out Medical Treatment or Research under Part 5 of the Act (2nd edn) (Scottish Government, 2007).

Code of Practice: Mental Health Act 1983 (Department of Health, 2008).

Mental Capacity Act 2005: Code of Practice (Department for Constitutional Affairs, 2007).

Standards on the use of Section 136 of the Mental Health Act 1983 (2007): (Version for England) (College Report CR149). (Royal College of Psychiatrists, 2008).

PROFESSIONAL GUIDANCE

Good Medical Practice 2013 (General Medical Council, 2013) (www.gmc-uk.org/guidance/good_medical_practice.asp).

Good Psychiatric Practice (3rd edn) (College Report CR154) (Royal College of Psychiatrists, 2009).

Good Psychiatric Practice: Confidentiality and Information Sharing (2nd edn) (College Report CR160) (Royal College of Psychiatrists, 2010).

Guidance on the Role and Effective Use of Chaperones in Primary and Community Care Settings (NHS Clinical Governance Support Team, 2005).

Guidelines for Mental Health and Learning Disabilities Nursing (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1998).

Mental Health Nursing of Adults with Learning Disabilities: RCN Guidance (Royal College of Nursing, 2010).

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- Royal College of Psychiatrists (2010b) *Self-Harm, Suicide and Risk: Helping People Who Self-Harm* (College Report CR158). Royal College of Psychiatrists.
- Royal College of Psychiatrists (2010c) *Self-Harm, Suicide and Risk: A Summary* (Position Statement PS03/2010). Royal College of Psychiatrists.
- Royal College of Psychiatrists (2010d) *Improving In-Patient Mental Health Services for Black and Minority Ethnic Patients* (Occasional Paper OP71). Royal College of Psychiatrists.
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