

Vulnerable patients, safe doctors

Good practice
in our clinical relationships

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Introduction

This report is a revision of *Vulnerable Patients, Vulnerable Doctors* (Council Report CR101, Royal College of Psychiatrists, 2002). Since that document was written, confidence in the conduct of some doctors towards patients has been undermined and there has been a re-examination of doctors' regulation and the standards expected of them. These standards – for example *Good Medical Practice* (General Medical Council, 2006) and *Good Psychiatric Practice* (Royal College of Psychiatrists, 2004) – deal with the whole professional role of the doctor, while the present report focuses on the therapeutic relationship. It places greater emphasis than its predecessor on the vulnerability of the patient rather than the doctor 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 guidance where appropriate (for example in the Appendix).

This booklet deals with the principles that should underlie any therapeutic relationship, not with specific therapies. The list of principles is not comprehensive; nor are the principles 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 self 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. While the 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 harm to doctors can be prevented, psychological, professional or to the reputation of their service.

Although the report is primarily concerned with the principles of conduct of doctors towards patients, it provides a description of how patient factors and organisational context can also damage or strengthen therapeutic relationships. Thus, the report can be read in part as providing 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 would apply where 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. The documents fall into three groups:

- general statements of rights, such as the Human Rights Act 1998, the United Nations Convention on the Rights of the Child (1990) and the Disability Discrimination Act 1995
- medical codes of conduct, for example the General Medical Council's (2006) publication *Good Medical Practice* and its statement of 14 key principles, 'Duties of a Doctor' (see <http://www.gmc-uk.org>)
- specialty standards, for instance as set out in the Mental Health Act 1983, the Mental Capacity Act 2005 and the Children Act 2004, *Good Psychiatric Practice* (Royal College of Psychiatrists, 2004) and *Good Psychiatric Practice: Confidentiality and Information Sharing* (Royal College of Psychiatrists, 2006), *Guidelines for Mental Health and Learning Disabilities Nursing* (United Kingdom Council for Nursing, Midwifery and Health Visiting, 1998), *Guidance on the Role and Effective Use of Chaperones in Primary and Community Care Settings* (NHS Clinical Governance Support Team, 2005) and *Positive Steps: Supporting Race Equality in Mental Healthcare* (Department of Health, 2007).

Principles of good practice in therapeutic relationships

1. DEVELOP SELF-AWARENESS IN THE SERVICE OF PATIENTS

Clinicians should develop self-awareness – 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 colours their reactions to the patient from their own attitudes, beliefs and experiences. 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 may be made to resolve a difficult relationship, one result of self-reflection can be an awareness that the therapist is temperamentally unsuited to work with a particular patient.

2. 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 that power with sensitivity and in their 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. The treatment 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 incapacity, 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, the elderly and those 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 should be strictly adhered to.

3. 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, 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.

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

4. 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.

The Royal College of Psychiatrists has produced guidance entitled 'Avoiding boundary violations in psychiatric practice', and this is presented in the Appendix (page 27).

5. BE CLEAR ABOUT ROLES

In the relationship with a patient, the doctor may perform many roles – as diagnostician, as supporter, as facilitator, as educator, as advisor, as advocate, or as 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 be driven by a desire to help, to provide non-professional advice without signalling clearly that they are doing so. When called upon to perform roles distant from core professional roles, 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 their relationship. Some 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.

6. 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 very different from the patient's but, through

self-awareness, the good clinician will be able to distinguish between them, enabling 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.

While it is no part of the therapist's role to persuade patients to conform to his/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 damage 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.

7. MAINTAIN PRIVACY

For trust to develop between patient and doctor there must be privacy in their relationship, which is not breached without consent. The right to privacy and the respect for private life is a well established ethical and legal right. Doctors have an ethical and legal duty to keep patient information confidential. A major source for this requirement is that the relationship between patient and doctor is one of 'fidelity' or 'trust' and that patients tacitly understand 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 duties. Disclosure should normally be only with the consent of the competent patient. Where doctors consider that disclosure would be in the best interest of a patient who is unable to consent, they should raise this with the patient's legal representative. In emergencies it may be impossible to keep patients and/or their legal representative properly informed and to gain their consent. In such circumstances, uses or disclosures may be made, but only the minimum necessary to deal with 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); and 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 Royal College of Psychiatrists (2006).

8. MANAGE RISK IN THE INTERESTS OF THE PATIENT

Risk can never be wholly eliminated from the doctor–patient relationship. The issue is how to manage that risk. Indeed, some degree of risk-taking may be necessary for the patient’s treatment and development.

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 to a particular problem.

Extreme behaviour may warrant the temporary take-over of control by the doctor in order to prevent undue risk to the patient or to others. Such measures (e.g. under the Mental Health Act) must always be directed towards demonstrable benefit to the patient. It is not part of the doctor’s role to contribute to containment for its own sake.

9. DEVELOP A CONTRACT OF MUTUAL RESPECT

Therapeutic relationships are founded on mutual respect. Respect breaks down when the expectations of the patient exceed the capabilities of the therapist; the result could be a negative ‘contract’ of blame and defensiveness. Respect is promoted when the capabilities of the therapist exceed the expectations of the patient.

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 must proceed at a speed the patient can manage towards targets the patient can achieve.

The aim of therapy is to effect change; but change cannot be assumed. All change is difficult. A patient is unlikely to change unless the pain of change is less than the pain of the patient’s current experience.

Reasonable compromises may have to be reached between the clashing expectations of the clinical team, the patient and the patient’s family or carers. There may be particular issues for families of ethnic minority patients.

The therapeutic alliance relies on trust; but it is safer for all if events are fully recorded. Conversely, no amount of annotation is a substitute for good clinical practice.

Factors undermining the quality of the therapeutic relationship

1. PATIENT FACTORS

(a) Decreased capacity

Patients' capacity to understand and make decisions in their best interests may be compromised by a number of factors, including intellectual disability, substance misuse, toxic confusional states, psychosis and the dementias.

Where patients have a long-term incapacity, it cannot be assumed that they are giving informed consent simply because they are compliant.

(b) Disempowerment

Patients may feel powerless because of their illness, the relationship with the doctor, the workings of the hospital, the housing or benefits system and unemployment. They may feel especially vulnerable if in extreme distress, physical or emotional, chronic or acute.

Patients who have the cognitive attributes for capacity may be disempowered by unfamiliar surroundings (children or the elderly especially), by sensory or communication difficulties and by the dominating influence of their situation (such as local authority care, prison or the hospital ward). Similarly, 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.

(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. Such groups 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.

(d) Previous experience

Patients who have been subject to physical, emotional or sexual abuse may distort the meaning of the doctor's behaviour because the therapeutic relationship unwittingly echoes the patient's previous traumatic experiences. Whatever their best therapeutic intentions, doctors must consider possible interpretations of their behaviour from the patient's point of view.

Taking advantage of the patient's vulnerability to misinterpretation, in however small a way, is reprehensible.

2. THERAPIST FACTORS

(a) Professional training, experience and support

All doctors are capable of attempting 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 through it. Senior doctors may act beyond their specialist knowledge or in isolation from peer-group advice, support or appropriate continuing professional development.

(b) Management

The doctor's position and the patient's confidence can be undermined where lines of clinical responsibility are unclear, or confused with service management requirements. Doctors may fail to act in the patient's best interest under the pressure of unrealistic expectations placed upon 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.

Many doctors have personal values derived from their upbringing or life experiences that may make them unsuitable for therapy with particular individuals or groups of patients with different values.

Doctors' ethnic or cultural background may affect their interpretation of a patient's symptoms or way of life, and their manner of relating to patients.

(d) Conflicting situations

There may be a conflict of roles. Doctors may be confused about what role is most appropriate in any therapeutic situation or may mistakenly attempt to perform several conflicting roles simultaneously.

There may be a specific conflict of interests, as when attempting therapy with someone known personally to the doctor or the doctor's family.

There may be conflicts with external agencies, service managers and colleagues or within malfunctioning teams; such conflicts may place the doctor under debilitating stress.

Finally, a doctor may be caught between conflicting principles, for example after receiving worrying information, within the confidence of a therapeutic relationship, about a third party, which must be acted on.

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 available.

4. CHARACTERISTICS OF TREATMENT

Techniques that involve a degree of emotional or physical intimacy (such as those incorporating touch or holding) could be perceived by the patient as intrusive and be open to misinterpretation.

Behavioural management techniques (especially involving control or restraint) could be seen as physically abusive.

Experimental techniques unfamiliar to patient or therapist, and of as yet unproven efficacy, are likely to be judged unsuitable, except in rare circumstances.

Although all of the above can have their place, the doctor needs to be especially aware of the dangers involved and seek to minimise them with advice, supervision and explicit consent.

Factors strengthening the therapeutic relationship

1. PATIENT EMPOWERMENT

(a) *'Knowledge is power'*

Patients should be fully informed about the proposed assessment and treatment process.

Allowance must be made for distress, anxiety and acute disturbance of the mental state, as these may make it difficult for the patient to absorb information. The patient may not remember being given information or may distort it.

Consultations should facilitate the exchange of information. Patients' views and wishes about their treatment need to be established. The psychiatrist's role and what the psychiatrist expects to provide need clarification at each stage of the assessment and treatment process.

Sensitivity to the socio-cultural context of the patient (including language) and ability to understand will aid communication.

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

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

(b) *Choice*

Clinicians should explain the choices available for the patient's treatment – where it is to take place (e.g. on an in-patient, day patient or out-patient ward), 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 needs to be discussed.

The patient or the family may want an alternative treatment. Steps need to be taken to help them to access this if, 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 patients 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 2007 or the Children Act 2004).

(c) Patient responsibility

Patients are not always aware of what is expected of them in the therapeutic process.

Patients should be helped to take responsibility for themselves for attending appointments, time-keeping and their behaviour in the out-patient and in-patient setting. The limits of acceptable conduct should be made clear with regard to the use of alcohol and drugs and abusive behaviour towards staff or other patients. Sanctions should be stated where appropriate.

The aim of therapy should be directed towards 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 under certain circumstances (e.g. for video-recording and for participation in research and teaching events).

(e) Advocacy, family support, interpreters and chaperones

The use of other people in a consultation may enable patients to communicate more effectively and to access a service, but the benefits of including others has to be balanced against the risk to the confidentiality between clinician and patient. Patients must usually consent to the presence of others unless there are good clinical reasons to disregard their wishes.

The patient may feel supported by the involvement of family members, friends or an advocate in the session and the patient's entitlement to involve them, where appropriate, 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.

Co-working with other members of the team or 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 more than one person in the room with the patient, a one-way screen allowing observation and intervention can be considered. This should be properly explained beforehand and consent for its use obtained.

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

(f) Second opinions

When patients and their families express doubt about diagnosis or the 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.

Reassurance should be offered that patients will not be discriminated against in their subsequent care if they question the 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 interest.

(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 for them to raise concerns if they suspect that abuse has taken place.

Formal procedures should be independent of the doctor or service concerned.

2. DOCTOR EMPOWERMENT

(a) Supervision

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

When clinicians recognise that a particular situation is potentially problematic, they should seek specific supervision for the case.

(b) Case-load management

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

Increases in workload when there is a shortage of doctors 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 management of patients.

(c) The multidisciplinary team

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

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

Unhelpful team dynamics, around power, rivalry and responsibility, can sometimes develop. This interferes with patient care and needs to be resolved. Opportunities for examination of team dynamics with an outside facilitator may reduce such risks.

(d) Professional development

Confidence in training and understanding protects the clinician from vulnerability in clinical situations. Continuing professional development is essential to maintain this confidence. Opportunities for learning new techniques and knowledge must be available. These should include time for private study as well as attendance at courses and conferences, locally and nationally.

Personal appraisal and monitoring undertaken sensitively 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.

(e) Clinical governance

Clinicians should be encouraged to participate fully in the organisation's clinical governance system, as well as being supported in their individual professional development. Sharing data on benchmarking, service comparisons both within and outside the organisation, patient surveys and outcomes helps clinicians appraise their own performance and that of the services in which they work. While doctors must use resources responsibly, deficits which 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 will reinforce 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 experience.

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

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

Experience of personal therapy, sensitivity groups, group relations events and participation in 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).

(b) Records

Written records protect the doctor and the patient. These 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.

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, the doctor should bear in mind that they may be read by the patient and that patients have a right to receive correspondence about them. Pejorative and value-laden statements should be avoided.

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

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

(c) Formal frameworks for professional conduct

All professionals are bound by the laws of the country.

Adherence to the professional codes of conduct laid down by the General Medical Council (2006) and the Royal College of Psychiatrists (2004) is expected.

Locally agreed procedures (e.g. for child protection) 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 these should be followed 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 may examine whether practice meets the standards for the therapeutic relationship described in this document.

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 when that is believed 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 such a responsibility.

Case vignettes

The following scenarios are entirely fictitious but each contains elements of the dangers outlined above. They are intended to assist training by stimulating discussion of the issues addressed in the text.

CASE VIGNETTE 1

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.

Where it is difficult to engage a patient in regular, clinic-based appointments, it is right to consider innovative ways of maintaining therapeutic contact. Home visits, 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 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 expectation after 'special arrangements' have been set up. The likelihood of the doctor engaging in purely social situations grows, with the potential of blurring of professional boundaries.

CASE VIGNETTE 2

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 residential home it is 8 p.m. The young 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 young 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 in question accuses the consultant of sexual harassment and abuse while visiting her in the residential 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. Indeed, the lateness of his visit in its own right 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 accompany him. On leaving the residential 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. Prompt and comprehensive exchange of information – in short, good communication between agencies – has a protective and containing effect. The consultant had very little ground upon 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.

CASE VIGNETTE 3

A female consultant is aware of her female patient's long-standing marital difficulties, which include domestic violence. She has on several occasions addressed these issues 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 immediately.

The consultant psychiatrist had, during the course of her management of the patient, correctly advised her to contact the appropriate local agencies, but she then has failed 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.

CASE VIGNETTE 4

A female consultant in the psychiatry of old age has a husband in the antiques and valuation trade. A female 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 for sale in the shop belonging to the consultant's husband articles that he remembers from childhood visits.

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 interest, regardless of the grounds. The relatives would be justified in their complaint.

CASE VIGNETTE 5

A female 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 appendicitis operation in the previous year. The surgeon's teenage daughter appears to have been depressed for several weeks, is not eating and, on some days, not even getting out of bed. She is refusing to see the family doctor or seek professional help. Her parents are very worried about her and have wondered whether the child psychiatrist could visit them at home in order 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. 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 breach the subject of family influences and fails to address the situation and to make the right 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 transgressions of boundaries. 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 very uncomfortable. She should have warned him that a home visit in the suggested circumstances would render her just as helpless as the parents.

CASE VIGNETTE 6

An unmarried male consultant psychiatrist moves to a small rural community. He works for the local psychiatric hospital. He 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 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 following the patient's discharge.

CASE VIGNETTE 7

A male consultant psychiatrist is told by a male patient that his wife has left him. The consultant is himself a divorcee. He tells his 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 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 should not be shared with patients, be they adults or children (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 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.

CASE VIGNETTE 8

An adult consultant psychiatrist practising privately is asked to see a famous actor by a mutual friend. There is no form of 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, because of potential media interest. The consultant is prevented by the patient from seeking 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. The course of therapy is prolonged. After eight 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 he will of course be expected to support his evidence with his hand-written documentation.

Full records protect the doctor and the patient. This ordinarily includes contemporaneous session notes, notes written immediately after a session, recording 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. He is unlikely to be able to ward off any potential criticism of his management of the case and may even be found negligent in carrying out his clinical duties.

CASE VIGNETTE 9

A junior female trainee on placement in a service for adults with intellectual disability is concerned about some 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 observed him comment upon his patients' physical appearance and dress, in a very intrusive manner, for example calling them 'fatty' and 'slow-coach'. In ward rounds he has made jokes at their expense and frequently talks about his patients in the third person. On other occasions he has been observed to shout at staff in front of patients. Her consultant's demeanour and clinical practice were making the junior increasingly uncomfortable. Following an incident when he used a dismissive racial epithet as he turned away, the junior doctor 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 that he was influential within the psychiatric establishment.

Even 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 as part of the induction process and the training of any new member of a clinical department.

Junior doctors should be assured of protection from any adverse consequence should they have a justified complaint, or reasonable ground for making even 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.

CASE VIGNETTE 10

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 and 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 session, 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.

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, his mother silences him. 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, because 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, as 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 well now not be able to treat this patient.

Appendix. Avoiding boundary violations in psychiatric practice

INTRODUCTION

While this document has been developed as the Appendix to this College Report, it is also designed to be read as a stand-alone document, which sets out the principles of professional boundary-keeping for all psychiatric practitioners.

BACKGROUND

The therapeutic relationship plays a greater part in psychiatric treatment than elsewhere in medicine and in some modalities is the only treatment. Maintaining a boundary between personal and professional identities is therefore a key competency for all psychiatrists. Sexual boundary violations represent the extreme end of the spectrum of boundary violations. Sexual boundary violations have been reported as causing significant psychiatric morbidity. Psychiatrists are over-represented among the doctors found unfit to practise by reason of sexual misconduct by the General Medical Council.

BOUNDARIES OF THE PSYCHIATRIC ENCOUNTER

A number of features help to provide the boundaries of the psychiatric professional encounter, all of which are the responsibility of the psychiatrist. These include:

- setting (hospital, clinic, care home or family home)
- time (usually within agreed service hours)
- duration (agreed and consistently maintained)
- use of appropriate professional language
- appropriate professional dress and insignia
- limited and socially sanctioned physical touch
- the patient's mental health needs, not social or sexual needs, being taken as paramount.

There is clear evidence that even minor violations of these boundaries may be damaging to patients. Some are unacceptable in any circumstances, while others are not always clearly harmful to patients. Even those not unequivocally harmful should raise questions for the doctor or patient about their appropriateness, but may not be finally judged except in their detailed context.

The commonest 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. Sexual violations are less common, but often start with apparently minor boundary violations, such as unjustifiably prolonged sessions, appointments out of working hours, treatment outside the normal place of work, except where 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 sees sexual boundary violations by doctors as serious professional misconduct and will normally remove the doctor from the medical register.

AVOIDING BOUNDARY VIOLATIONS: A PRACTICE GUIDE

Good practice principles are listed below. There will always be occasions when these principles may be breached. The onus will then be on the practitioner to show how those breaches contributed to a therapeutic outcome and to show that they were not anti-therapeutic.

- Sexual relationships with patients or former patients are unethical and unacceptable.
- Physical touch beyond normal social exchange should be used with caution. A 'no touch' policy is unworkable and may be anti-therapeutic, but the inherent power imbalance between professionals and patients means that touch of any kind may be misinterpreted.
- Inappropriate self-disclosure (the commonest form of boundary violation) or disclosure of confidential personal material without consent should be avoided. Psychiatrists should make themselves familiar with the guidance on confidentiality produced by the Royal College of Psychiatrists (2006).
- Treatment or therapy should generally not take place in a practitioner's home. 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).
- 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.
- 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.

- 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 Axis II disorders), supervision is essential and practitioners will have to justify why they did not have an identified supervisor if they fail to do so and their work is questioned.
- Psychiatrists should avoid being in dual roles with patients, for example being both the responsible medical officer (RMO) and psychotherapist. As stated in *Good Medical Practice* (General Medical Council, 2006), psychiatrists should avoid treating family members, friends, family of friends, colleagues or family of colleagues. This is particularly true in cases where the patient is a doctor (e.g. a fellow psychiatrist).
- Other role conflicts include issues relating to money and dual relationships. Psychiatrists should not appear as expert or professional witnesses in cases where they know the patient in a psychotherapeutic relationship. They may act as professional witnesses but will be bound by their duty of confidentiality in the ordinary way (see Royal College of Psychiatrists, 2006). There are rare occasions (usually in forensic psychiatry) where the RMO can also act as an expert witness as well as a professional witness. In such cases, the RMO needs to consider the legal questions carefully and advise the court of a possible conflict of interest. Junior staff should not be placed in situations of role conflict.

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