The College

Child Psychiatrists and the Organization of Child Guidance Clinics

A Note on Aspects of Clinical Responsibility*

1. The recent development and diversification of assessment and intervention techniques together with the strengthening of the professional identity of disciplines allied to child psychiatry has resulted in changes in working arrangements in Child Guidance settings. A recent informal survey[1] suggests that this has led to ambiguities in the role of the child psychiatrist, which are eroding the service provided to patients as well as their job satisfaction.

It was clear that some child psychiatrists were getting very poor support from their Area Health Authorities, in terms of both staff and facilities and in being able to exercise medical responsibility. Colleagues seemed particularly to regret any breakdown in multidisciplinary work, but at the same time were having to cope with situations where their leadership of the team had ceased to be acknowledged. In some cases confidentiality was being endangered and in others there were dual loyalties, Child Guidance staff being answerable to their parent agencies (Social Services and Education) as well as to the Child Guidance Clinic. The recent Brunel Paper, 'Organization of Services for the Mentally Ill' (B10SS Rowbottom & Hey 1978) outlines the choices to be made in the organization of services involving different disciplines, and concludes (Page 20, para 53).

> 'Given these clear choices, what seems hardly acceptable is to respond to dual influence problems by refusing to be specific about organizational relationships on the grounds (often put forward) of retaining necessary 'flexibility' in the situation. Nor is it an adequate response to press all concerned to try to be more "open" or "mature" in their personal inter-relationships, or to cultivate more "team spirit". Desirable though all these things may be in their own right, they are not in fact likely to be promoted by refusal to sort out basic structural problems.'

2. The College has set out its view of the roles and responsibilities of a consultant child psychiatrist in a recent publication[2]. The College is represented on an Interdisciplinary Working Party which is considering the organization of Child Guidance services and will be reporting shortly with recommendations which it is hoped will be helpful in solving some of these basic structural problems. In the meantime the following notes are intended to give guidance to consultant child psychiatrists about their professional and legal obligations when working arrangements are being negotiated.

*A memorandum prepared by the Executive Committee of the Child and Adolescent Psychiatry Section.

3. We consider it good practice for consultants to ensure that they have close contacts with the other professions that work with children. This is best achieved by having a common base from which to work or by meeting frequently and regularly. It is necessary for consultants to address themselves to two important issues of medical responsibility laid down by the General Medical Council[3] in these situations. They must ensure *confidentiality* and they must ensure *adequate and appropriate treatment* for their patients. Allied disciplines operate similar codes but doctors have had the longest association with this ethical tradition and it is only in their case that it is so clearly backed by the possibility of legal sanctions. In addition, doctors have to carry malpractice insurance as a condition of their appointment.

4. The implications of this are that child psychiatrists have to be able to exercise sufficient control over issues of confidentiality and over the quality of treatment offered by any team with which they are associated, so that they can fulfil the criteria set out in the General Medical Council document. In practice, the consultant should have influence over the selection and appointment of other staff, and other staff should in circumstances previously agreed to by them accept direction from the consultant over matters relating to confidentiality and treatment of patients. This applies in cases where patients are referred to the doctor or in clinics where the doctor has some clinical responsibility (as defined in the job description (6.f)), whoever actually sees the patient. We would naturally respect the right of senior members of other disciplines to make similar requirements of the multidisciplinary team.

5. In any service for which the National Health Service is wholly or in part responsible, the administrators must ensure that the consultants have the conditions which are compatible with the exercise of their medical responsibility. In consultative settings where he does not carry out clinical work, the doctor must make it clear that he is there to advise staff and is not responsible for the clinical care of the children in the establishment.

6. An intermediate situation arises where child psychiatrists offer a service in those Child Guidance settings administered by the Education Service. This requires particularly careful negotiation, but the following points may help to ensure that medical responsibility can be discharged: (a) selection of staff: the child psychiatrist should be in a position adequately to influence the selection of professional, administrative and clerical staff to the clinic; (b) if the medical input is so slight that this is not possible, the child psychiatrist should be sure

that he is satisfied with the staff with whom he actually works and be prepared ultimately to withdraw his service if his needs are not met; (c) he should ensure that there is a clear distinction made between cases that are referred to him and that he is involved with and those where he is not involved; the latter are then clearly not part of his responsibility; (d) he needs also to make it clear that in cases referred to him, and in others where he is consulted, he needs to have some continuing oversight until the children are discharged from the clinic; (e) if he receives no guarantee about confidentiality of notes in the clinic, in general, he should consider whether he should have a separate filing cabinet for his own notes; (f) it would be helpful if job descriptions for new consultant appointments made clear what was the extent of consultants' responsibilities for children referred to the team and not to him by name.

7. An allied problem is that of leadership. This has been diffused in the same way as medical responsibility, with the strengthening of the professional identity of other disciplines. The voices of the multidisciplinary team echo weakly in the corridors of power, especially where there is no clear leader to negotiate for resources or where the Health Service is seen as the 'poor relation' compared with other services. There needs to be a clearly designated team leader, and if this is not the consultant psychiatrist the clinical responsibilities of his work which cannot be directed by non-medical team leaders must be clearly separated from other leadership roles.

FOOTNOTES

1. Presented at the Section's Annual Residential Meeting, Cambridge, September 1979.
2. 'The Role, Responsibilities and Work of the Child and Adolescent Psychiatrist'. *Bulletin*, July 1978, p. 127.
3. The General Medical Council in their guidance on professional conduct and discipline (May 1977) state: 'It is the doctor's duty strictly to observe the role of professional secrecy by refraining from disclosing voluntarily to any third party information which he has learned directly or indirectly in his professional relationship with the patient'. The Council would also regard it as a breach of medical responsibility if:
   (a) a doctor failed to 'provide or arrange treatment for a patient when necessary' and
   (b) the doctor delegates treatment or other procedures requiring the knowledge and skill of a medical practitioner to someone without satisfying himself that 'the person to whom they are delegated is competent to carry them out'.

   The Council go on to say, 'It is important that the doctor should retain ultimate responsibility for the management of his patients because only the doctor has received the necessary training to undertake this responsibility'.

*General Practice Trainees in Psychiatry**

The joint Liaison Committee of the Royal College of Psychiatrists and the Royal College of General Practitioners has recently agreed to guidelines dealing with the experience that would be desirable for a general practitioner trainee occupying a post in psychiatry. The draft Guidelines have now been accepted by the Councils of both Colleges and are commended to all those concerned with the psychiatric education of vocational trainees in general practice.

Experience desirable for the General Practice Trainee occupying an SHO Post in Psychiatry: Guidelines

Introduction

Suitable hospital experience is recognized to be an important part of postgraduate preparation for general practice. The concentration of clinical material and the ready supervision by appropriately experienced colleagues can rapidly enhance clinical skills and help to bring about professional maturing with a general gain in competence and confidence. First-hand knowledge of hospital procedures and of what hospitals can offer is of importance to general practitioners. At the same time a perspective on the relationship between general practice and specialist services is achieved from the hospital standpoint.

The following notes are intended as pointers to areas of knowledge and clinical practice in psychiatry with which general practitioners should be familiar, and to enable psychiatric consultants to help their general practitioner trainees occupying SHO posts to acquire a sound basis for their future practice of family medicine. The relationships established in this way can be of great benefit to both branches of the service, as well as to patients.

Local conditions will undoubtedly influence the way these proposals are implemented, and variety of approach is not only to be expected but welcomed. Close co-operation will be required between a number of individuals, particularly the regional postgraduate adviser in general practice, the Royal College of Psychiatrists' regional adviser, the local psychiatric tutor and the vocational training scheme organizer.

The immediate objectives of the general practitioner trainee and the trainee psychiatrist may differ in a number of important respects. For instance the requirements of the respective postgraduate examinations are different and the emphasis on range and content of training also differs. On

*See also *President's Press* on page 86 of this issue.

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