RESPONSIBILITIES OF CONSULTANTS IN CHILD, FAMILY AND ADOLESCENT PSYCHIATRY*

A Personal View

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This paper discusses the special problems of consultants' responsibilities in child and adolescent psychiatry, following the College memorandum (*Bulletin*, September 1977, pp 4–7). In particular consideration is given to the implications of consultants working in multidisciplinary teams and attached to clinics, residential homes and schools administered by the Local Authority. Ever since 1927, when Emanuel Miller opened the East London Child Guidance Clinic, a multidisciplinary team approach has been the elected method for dealing with psychiatric problems of children and their families.

The arrangements for providing a consultant service in child psychiatry vary a great deal throughout the United Kingdom, and it is possible for one consultant to be working in a variety of different ways in one health district. These variations are in part of historical origin.

Hospital out-patient clinics for child and adolescent psychiatry, and clinics in the community which are staffed from and seen as offshoots of hospitals, have expected the consultant to take the lead in developing policy to take a personal interest in organizing the clinic in the same way that his surgical colleague will organize his operating theatre. Each member of the team is responsible for his part of the team work, but the consultant is clearly recognized as having overall clinical responsibility for every patient referred to him. (All referrals to such a clinic will be automatically allocated to a consultant.) This system has the advantage that it clearly defines where final responsibility lies. The onus is on the consultant to see that a good service is provided. To do this he must be able to have some influence on the job description and selection of other team members, and on the policies of the clinic in relation to case notes, letters and reports (confidentiality). Since referral is to the consultant, the consultant must be in a position to control the consequences of the referral to the patients and their relatives.

Traditional child guidance clinics grew from concern about children who were failing to adjust in the community, presenting difficulties in school, or appearing in the Juvenile Courts. Psychologists, psychiatric social workers, child psychiatrists and sometimes child therapists, brought their expertise together to help the child and his family as seemed appropriate. Theoretically, responsibility is shared by the team, greater responsibility being taken by those members whose expertise is most appropriate for solving the particular problem. Nevertheless, the first such clinics were all established by one strongly interested person, in most cases a doctor, who directed the proceedings. Under these circumstances, co-operation between the participants was the starting-point.

During their evolution child guidance clinics have expanded their functions, so that in many areas they now provide an out-patient, diagnostic and treatment service for the full range of psychiatric disorders in childhood and adolescence. With the development of the techniques of family therapy, they are dealing with an even wider range of family disturbances.

At the same time changes have occurred in the organization of the professions of social work and psychology. The new organization is more hierarchical and the individual professional is expected to be responsible to his department head and not to the child guidance team. These changes have highlighted potential difficulties present throughout the development of the child guidance movement, but not previously of special importance in practice.

In 1960 the Child Psychiatry Section recognized this issue in producing a document on the function and responsibility of the child psychiatrist as director of child guidance clinics, and more recently the College has published a policy statement about the responsibility of consultants in psychiatry within the NHS. In this document multidisciplinary team work is discussed fully. True multidisciplinary team work at clinical levels is recommended as probably the most effective way of staff co-operation in the treat-

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ment of patients, provided that each member of the team is given full power to make clinical decisions. This implies that hierarchical discipline (e.g. social work, nursing and psychology) should devolve clinical, as contrasted with administrative, responsibility and power to their members. Team work is eroded if any member of the team has divided loyalty, is unable to take decisions, or can appeal to an authority outside the team to challenge the team's decisions.

A consultant is legally responsible for the consequences of his professional activity. It is essential therefore, that he should be able to exercise control over these activities. Difficulties can occur when the consultant's professional associates or secretarial and administrative helpers are not employed by the same authority or governed by the same code of ethics and do not see themselves as under the consultant's clinical direction. Difficulties can also arise where the consultant is unable to exercise control over policies about such matters as referrals, confidentiality, distribution of case notes and information given to other agencies. Policies on these matters can differ profoundly between education authorities, social services departments, administrators and the medical profession. While requiring a high standard of professional expertise and confidentiality for their personal health service, officials often fail to recognize that pupils in school and families coming to the notice of the Social Services Department deserve the same consideration. Like other doctors, the child and adolescent psychiatrist is dependent for the success of his interventions on the trust and respect of his patients and their families. The general public has special expectations of a doctor. These expectations include (1) That they can talk to him in confidence about very private and intimate matters, that they will be listened to respectfully and uncritically and that their confidences will not be divulged to any other person without their consent. (2) That the doctor will take full responsibility for everything that happens to them while under his care, or as the result of his advice. (3) That all the people who work with him are under his direction, that he knows what they are doing, that they consult with him before taking action and tell him what the patient says to them, and that the same rules of confidentiality apply to these other people as apply to the doctor himself.

Of delegation, the GMC states 'A doctor who delegates treatment or other procedures must be satisfied that the person to whom they are delegated is competent to carry them out. It is also important that the doctor has received the necessary training to undertake this responsibility' (GMC 177, pp 10). Of professional confidence, the GMC reiterates the guidance given by the BMA (*Medical Ethics*, 1974, pp 13–14): 'It is the doctor's duty strictly to observe the rule 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.' Exceptions are made when the patient or his legal advisor gives valid consent, or the information is required by law. 'If in the doctor's opinion, disclosure of confidential information to a third party is in the best interests of the patient, it is the doctor's duty to make every reasonable effort to persuade the patient to allow the information to be so given. If the patient refuses, then only very exceptionally will the doctor feel entitled to overrule that refusal.' 'A doctor should be prepared to justify his action in disclosing confidential information.' Apart from any legal or ethical consideration, we as psychiatrists must be aware that we cannot work with patients who conceal vital information because they do not trust us.

The association of a doctor of consultant status with a place called a clinic endows that establishment with a medical aura. The public and other medical practitioners will expect that all cases referred to that clinic will be investigated and treated under the direction and supervision of the doctor or doctors there, that they will know what is being done by other members of staff and will take ultimate responsibility for it. The clients will expect that their confidences will be treated as if given directly to the doctor, even if they were in fact given to other staff members. They will not expect the fact of their attendance to be made known to any outside agency such as a school teacher or social worker without their consent, and will certainly not expect their confidences to be made known to anyone outside the clinic. The families of children attending such clinics would not expect that their attendance there would be automatically recorded on the child's school record, or even his school health record, or in a Social Services Department. It would be even more unacceptable if copies of reports about the child or his family affairs were automatically filed at the local or Central Education Office or Social Services Department.

In my view, it is not sufficient for the doctor to keep his own personal notes private. If the patient came with the expectation of a medical service he will have given confidences to social workers and psychologists or to a secretary as if to the doctor, and they must be bound by the same rules, and this must apply whatever authority is responsible for the provision of the premises or the non-medical staff. This should not be seen as an interference with the

professional autonomy of other staff members, since they must be responsible for the quality of their own professional work and may themselves have rules about divulging information; for example, doctors must respect the view of psychologists that results of IQ tests should not be divulged to parents or to family doctors, and of social workers and psychotherapists that details of casework or psychotherapy should not be divulged outside the clinic. No difficulty arises where the work of a team is based on the mutual respect and goodwill of its members. Rules become necessary, however, where this has not been established or where administrators have failed to grasp the necessity. It should be made clear to administrators of Health and Social Services and of Education, that doctors cannot work in a setting where these rules are not accepted.

The nature of the doctor's responsibility implies that in any setting where he has to provide a clinical service, investigation or treatment, he must have a sufficient measure of control over any staff who work with him to enable him to exercise his responsibility. Usually this would mean that he would have influence over the selection and appointment of other staff and that other staff members would accept some direction about matters relating to confidentiality and to the investigation and treatment of patients. Doctors must have power to influence all policies relating to referral, documentation and reporting about patients that are referred to them or to a clinic where they appear responsible, whoever actually sees the patients.

When a doctor visits an establishment controlled by non-medical staff (other than on domiciliary visits), it must be made plain that he is there in an advisory capacity and is not responsible for the activities of the staff or the care of clients in the establishment. He must ensure that other agencies are not led to believe that he exercises any control or responsibility for the activity of the establishment, and that his name is not used to mislead the public in any way. He must take responsibility for the effect of his advice if it is taken correctly. He must therefore ensure that it is understood, but he cannot be held responsible if his advice is not taken or is misapplied. It is usually wise to separate the functions of supporting, advising and counselling staff from the investigation and treatment of patients, because of the difficulty of maintaining confidentiality and trust if the two functions are combined. Both staff and residents will assume that the doctor will talk to the staff about interviews with the residents; residents will therefore tend not to believe the assurance of confidentiality, and staff will be annoyed by the doctor's refusal to discuss his interviews.

It is doubtful if a doctor can safely work in an establishment where his responsibility for clients is not clear to the referring agencies and the clients themselves. If some cases are referred to the non-medical staff direct, others to the doctor, and yet others to 'the team', confusion can arise about the question of medical responsibility and confidentiality. If a referral seems to be to a doctor initially, but is not seen by the doctor, or is passed on by non-medical staff, this must be made clear to the referring agency.

Conclusion

Harmonious team work is essential to the successful practice of child, adolescent and family psychiatry. Equally essential is the trust of the family which stems from their knowledge that consultants in child psychiatry are bound by the same ethical rules as other members of the medical profession. Erosion of this trust to gain short-term goodwill from non-medical colleagues can only lead to long term harm to the overall work of the team. Each team member must be aware of, and sympathetic to the special constraints on the other disciplines of the team. The particular constraint on the consultant is that wherever he is working, he must take full responsibility for the effect of his work; he must therefore, be in a position to control its effect at all times, and must avoid a position where he cannot. Failure to recognize this by non-medical colleagues and administrators, leads to disharmony and ineffective work.

References

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