columns

energy. As a pioneer in his field in the West Midlands, he was instrumental in recruiting junior staff into old age psychiatry. He was the first to represent the West Midlands on the Faculty Executive in its early years, and during his tenure of office as chairman of the Regional Higher Training Sub-Committee, the West Midlands was one of the first regions in the country to set up a separate training scheme for old age psychiatry. His commitment during those years in office was instrumental in a strong foundation being laid for this scheme, and it is part of his legacy that his strength has endured. The major contribution he made to his speciality was recognised with his election to FRCPsych in 1985, and he was further rewarded with the granting of FRCP in 1995. He was a fine clinician and a caring, compassionate doctor. As a colleague he was strong in support, and a team player.

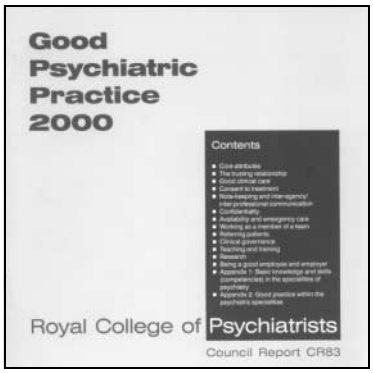
Following his retirement in 1999 he kept up his lifelong interest in politics and devoted his energies to creative writing, computer studies, travel and, above all, to the interests and wellbeing of his family. He was a loving and devoted husband, father and grandfather. His wife and their five children and two grandchildren survive him.

Tom Fenton
Elizabeth M. Gregg

reviews

Good Psychiatric Practice 2000. Council Report CR83

By Royal College of Psychiatrists. London: Royal College of Psychiatrists. 2000. 48 pp. £5.00. ISBN: 1-901242-57-9



This report is the College's contribution to a process that all Medical Royal Colleges are undertaking, the purpose being to set out standards of acceptable practice for the appraisal and revalidation of doctors. It sets out standards for psychiatrists, and juxtaposes these with relevant sections of the General Medical Council's (GMC) *Good Medical Practice*. The first edition of *Good Psychiatric Practice* welcomes comments for improvement, which is just as well because the document leaves plenty of scope for this.

The difference between medicine and psychiatry emerges starkly in the first section on the importance of trust in doctor–patient relationships (pp. 5–6). Among other things, the GMC document stresses the importance of respecting patients' rights to be fully involved in treatment decisions, and their right to decline treatment. The College report goes as far as acknowledging that there is a 'difficulty' in psychiatry, where those with mental illness may have a different view of their needs from their carers or, more significantly, their psychiatrists. The relationship between doctor and patient in psychiatry and medicine is not the same. Most patients would accept the view of a physician that their chest pain on exertion occurs because their coronary arteries are narrowed. Many psychiatric patients reject the notion that they hear voices because they have a condition that psychiatrists call schizophrenia. Everybody knows that if you decline treatment for angina, no one will force you to take it. This highlights a fundamental weakness of the College report; it fails to acknowledge or grapple with the complex ethical dilemmas that arise when patient and psychiatrist fail to agree on how to understand the nature of the patient's experiences. This failure demonstrates how important it is that we explore the issue of the contested nature of mental illness, both conceptually and ethically. If you like, it demonstrates the need for clinical practice to be combined with a critical philosophical analysis.

This becomes even more apparent when we consider the issue of consent to treatment (p. 15). Conflicting interpretations of mental illness imply conflicting notions of how we should act. Recent user-led research (Mental Health Foundation, 2000; Rose, 2001) has illuminated this complex area, demonstrating the need for a diversity of responses. While many service users find medication helpful, many are profoundly unhappy that psychiatry can be used to impose on them a biomedical interpretation of their experiences. This means that good psychiatric practice must involve a great deal more than 'awareness of the rights of the individual', or 'engaging patients . . . in full and open discussions about treatment options', and it is sad that the document makes no mention of the role of advocacy or advance directives here. Advocacy is extremely valuable in the difficult ethical negotiations around treatment, especially where coercion is involved (Thomas & Bracken, 1999). Psychiatrists' understanding of advocacy leaves much to be desired (Lacey & Thomas, 2001), so the report's failure to refer to advocacy is even more significant bearing in mind that the new Mental Health Act will attach particular importance to advocacy for detained patients. Likewise, advance directives can play an important part in extending competence when service users are temporarily not competent to make decisions about their care. Although the legal status of these documents has yet to be established, it would have been helpful if the report had made some reference to advance directives. At the very least there might have been encouragement to the profession to try and respect a patient's directive.

The expression 'good psychiatric practice' suggests that we should be concerned above all else with values. Sadly, this document really fails to grapple with the complexities that arise when different values and beliefs conflict in the area of mental health. Given the changing context of mental health care, one that accords greater prominence to users' voices, in the shadow of a Mental Health Act that represents a significant shift from care to coercion, this document will fail to move our practice with the times. But it is a start, and if, as the foreword indicates, there is a willingness to listen to comments, we may yet move on.

GENERAL MEDICAL COUNCIL (1998) *Good Medical Practice*. London: GMC.

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This booklet is the first edition of what is hoped will be the key document setting out agreed standards for practice in psychiatry. The introduction welcomes

https://doi.org/10.1192/pb.26.7.278-a Published online by Cambridge University Press

columns

comments and suggestions for improvement, as it is 'anticipated' that it will aid in 'appraisal and revalidation of medical practitioners'. It is thus a first stab at outlining requirements, and should be carefully read by all of us.

The format is clear and quite formal, aligning excerpts from the GMC *Good Medical Practice* (1998) publication with key points from the College relative to that area on the opposite page. Topics covered include core attributes, good clinical care, confidentiality, working as a member of a team and clinical governance. There are also sections on teaching and training, research and consent, and two appendices. Appendix 1 comprises the basic knowledge and skills (competencies) and Appendix 2 goes through good practice within each separate speciality.

There is, not surprisingly, nothing very surprising in all this, in that the majority of statements are straightforward, uncontroversial and what anyone would expect of a good doctor. Thus, examples of unacceptable practice include 'communicating poorly with others' and 'acting against the best interests of the patient'. Good practice by contrast involves such things as 'being open to peer review' and 'only signing documents when assured as far as possible that the information is correct'. The College's responses, in fact, are divided into good and unacceptable practice, by and large, and it would be surprising if any College Member really did not know these core principles. The sceptic might consider that there is an element of spoon-feeding here, but there are one or two more controversial statements.

For example, among the examples of unacceptable practice, under the section entitled the trusting relationship, is apparently the 'abuse of power relationships within the team and in the therapeutic alliance'. This seems somewhat subjective in its understanding, and one might ask why not simply use the term 'bullying', as is used in employment tribunals? Under the consent to treatment section it is suggested that unacceptable practice includes an 'unwillingness to recognise the importance of seeking advice when children are at risk'. But one might ask why not also seek advice when adults, the elderly or other individuals with specific disabilities are at risk? Others might ask what the phrase 'formative assessment' means in the context of teaching and training, and question what is meant by an 'overcritical attitude' towards trainees. Again, is this not somewhat subjective, in that because a trainee feels criticised is that going to be sufficient evidence for the trainer being deemed 'overcritical'?

This lack of specificity is also seen in Appendix 2. Thus there is a large difference in the range of items required for general adult psychiatry (10 bullet points) as compared to the psychiatry of learning disability (17 bullet points). The speciality of substance misuse requires skill in risk assessment and 'knowledge of the spectrum of effective pharmacological treatments', but the term risk assessment is not included in the general adult psychiatry section. By contrast, general adult psychiatrists are asked to develop good practice in understanding, prescribing and monitoring the side-effects of a range of pharmacological therapies. What is clear, in fact, is that a lot more work needs to be done on boiling down these specialist roles, since there is both a lot of overlap, a lot of bland generalisation and a lot of the somewhat obvious. For example, under the forensic section there is required 'an understanding and awareness of issues relating to ethnicity, culture, gender and sexual orientation', which is fine, but not specifically forensic. Psychotherapists are enjoined to undertake 'regular supervision of own work' (and why not for everyone?), while liaison psychiatrists must have 'knowledge of specific interventions'. This whole section needs radical review.

Overall, of course, this kind of booklet does need to be published, since at its core is a sensible summation of good practice. It would benefit from a co-ordinating and purifying editorial hand, and from trying to avoid the unnecessarily obvious (e.g. 'listen to members of the team') and the tendency towards being something of a wish-list ('ability to be decisive'). It is clearly the task of every thoughtful psychiatrist to read it, report his or her concerns, positive and negative, to the relevant division or faculty and for the College to refine it further for the future.

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The historic importance of this innocuous looking booklet is easy to miss at first glance, despite the warning in the introduction that it will assist in the appraisal and revalidation of psychiatrists. Comparison with the GMC's *Good Medical Practice* on opposing pages shows not only the superiority of the GMC prose, but also that good psychiatric practice seldom deviates from that which is to be expected of any doctor. The need for integrity, honesty, respect for colleagues and personal probity is rehearsed in both documents, becoming repetitious and eventually tiresome in the one under discussion. Due attention is paid to the vulnerability of patients, especially those unable to consent and the need to ensure the rights and safety of children. There is occasional overkill: is it really necessary to specify that a psychiatrist must achieve competence in taking a history and conducting an examination of mental state? Will cardiological guidelines specify competence in auscultation of the heart? Specialist sections offer their authors (committees?) golden opportunities to strut their stuff, reminding us that the College is unusual in recognising six or seven different types of psychiatrist. Psychotherapists forbid themselves from using treatments that lack sufficient basis in scientific evidence. If they are anything like the rest of us this should leave them plenty of time for continuing professional development! It is to the psychotherapists' credit that it is in their section alone that one finds reference to improper relationships with patients. Prohibition of sexual relationships with patients is never explicit but therapists should be 'sensitive to the psychological implications of transgressing boundaries e.g. through touch and/or self revelation'.

Scattered throughout the report is a litany of exhortations that have less to do with clinical competence than with straight delinquency. Thus, the good psychiatrist will, *inter alia*, cooperate with confidential enquiries, take due note of guidelines from various organisations and avoid making autocratic decisions, falsifying clinical notes or 'deliberately flouting regulations'. The only reference to the primacy of patient needs is a Delphic statement on p. 13: 'the psychiatrist will be able to judge the ethical implications of management requirements and take appropriate action'.

The report is a radical departure from the traditional role of the College as the arbiter of standards of education and training, to one of social policeman who peers into every nook and cranny of the lives of psychiatrists. If the spin of this report proves typical of similar documents from other Colleges, some will think that Faustian bargains have been struck with a government determined to put doctors in their proper place.

Questions, the answers to which lie outside the scope of this review, inevitably arise as to how this report will be used, to what purpose and by whom. Wedded as it is to the GMC and clinical governance in the UK, its provisions cannot apply to psychiatrists in Ireland, where separate (and hopefully better) arrangements will be needed in keeping with emergent legislation. Only time will tell if these developments will strengthen psychiatric practice in these islands; possible benefits to patients are even harder to predict.

There are some good things here. In its broad sweep the report goes where none has gone before. At least it calls a patient a patient as distinct from a client or service user. An alluring advertisement to

https://doi.org/10.1192/pb.26.7.278-a Published online by Cambridge University Press