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CAROLINE JACOB, ELUNED DORKINS AND HELEN SMITH

Patient choice in forensic settings: managing requests for change of consultant

The National Health Service (NHS) is undergoing extensive modernisation. Central to this process is the move away from a professional-led health service to a patient-centred system, which offers patients the 'power' to make decisions about their healthcare. In 2003, the government announced their plans for 'patient choice' within the NHS (Department of Health, 2003).

The dictionary definition of 'choice' is (a) an act of choosing, (b) the right or ability to choose, (c) a range from which to choose or (d) something chosen. The Department of Health's meaning of 'choice' has transpired to be offering patients a choice of providers of care or hospitals, particularly for elective surgical procedures. (See Department of Health (2003) and (2004) for further information on patient choice and the 'choose and book' policy.)

Many of the Department of Health's documents focus on medicine and surgery, although the guidance encompasses all specialties, including mental health. In response to this, the National Institute for Mental Health in England (NIMHE) has written 'checklists' for promoting choice within mental health settings and has created a website on the topic (http://www.csip.mhchoice.org.uk). Leading mental health charities such as Rethink have supported publications on implementing patient choice (Rankin, 2005) and in the *National Service Framework for Mental Health – Five Years On* (Appleby, 2004), the need to move towards patient choice in mental health was highlighted.

There are differences between psychiatry and other medical specialties that become important when considering patient choice. The compulsory treatment of individuals with mental illness has been part of psychiatry and English law for centuries and clearly has an impact on issues around choice. Within forensic psychiatry, most patients are detained under the Mental Health Act 1983, some with additional Home Office restrictions on their care. None of these decisions have been within the patient's control or subject to their choice. The majority of these patients have also committed criminal offences and their detention in hospital is often an alternative to a custodial sentence.

An issue that has been raised on several occasions regarding the care of mental health in-patients in a forensic setting is that of the management of patients' requests for change of consultant (responsible medical officer or RMO). Although we focus here on experiences within forensic psychiatric settings, many of the factors discussed, including psychodynamic concepts, risk management, continuity of care and organisational issues are likely to be applicable to other psychiatric specialties.

Patient choice and change of consultant

There is little evidence to support practice in this area. In a survey of general adult psychiatric patients, Hill & Laugharne (2006) found that 42% rated choice of clinician as 'very important' or 'essential'. This was not specific to consultant psychiatrist choice. A MORI poll commissioned and cited by the Department of Health (2003) states that 31% of individuals surveyed would like a choice of doctor.

The issue of consultant choice is raised in the Independent Inquiry into the death of David Bennett (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority 2003). David Bennett was an African–Caribbean male with a diagnosis of schizophrenia. He was detained under section 3 of the Mental Health Act 1983 and was an in-patient on a forensic unit. He died in 1998 during a control and restraint procedure. The Inquiry published a list of recommendations and item no. 19 highlighted the following:

> '. . . all psychiatric patients and their families should be made aware that patients can apply to move from one hospital to another for good reason, which would include such matters as easier access to their family, a greater ethnic mix or a reasoned application to be treated by other doctors. All such applications should be recorded. They should not be refused without providing the applicant and their family with written reasons' (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003: p. 72).

Psychodynamic issues

Within the forensic psychiatric population, many patients present with difficulties establishing and maintaining relationships. A significant number have histories of

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childhood deprivation and abuse, inconsistent parenting and chaotic family structures. These early experiences form a framework for the individual's future relationship interactions and consequently many have experienced unpredictable, rejecting and volatile relationships in adulthood. These people have suffered early alienation from individuals who may have offered them trust, love and help. In adult life, this presents as a belief that care equals abuse or that carers are potential abusers (Hinshelwood, 2002).

With modernisation of mental health services and the move from in-patient-based care to community-based care, the days of 'institutional' psychiatric hospitals have passed. However, forensic psychiatric hospitals continue to provide long-term care for people, many of whom are resident in a facility over a period of years before discharge.

Within these settings, relationships between staff and patients develop over years. This long-term contact creates attachments between patients and staff and potentially the unconscious re-enactment (through transference, countertransference and projective identification) of relationship dynamics that originate in the patient's family. Admission to a forensic unit is a stressful process, often severing any links of stability that the person had established in the outside world. Anxiety triggers an individual's attempts to find security in relation to another and hence promotes behaviour in patients that may be reminiscent of their earlier experiences with primary care givers (Adshead, 2003).

Following on from this concept, the RMO represents an authority (parental) figure and will attract associated feelings through transference reactions and projective identification. The consultant and/or team may unconsciously become the recipients of projections of the patient's own internal persecutory feelings. Subsequently they unconsciously enact a role in relation to the patient that mirrors previous relationship dynamics in the patient's life. This may result in the individual's perception of failed care by the consultant and/or team and an inability to progress within that relationship. This may also be reversed, the patient becoming the recipient of team anxieties and projections, leading to scapegoating and other phenomena.

As individuals unconsciously project aspects of their inner world into staff members, staff may become split into 'good' and 'bad' figures (from the patient's perspective). The clinical team may also find themselves divided in opinion between those holding supportive and empathic feelings towards the patient, and those perceiving the patient as 'bad'. The idealisation of certain 'good' staff members and the projection of hostile feelings into the 'bad' consultant may result in requests for a change of consultant, only for the same thing to happen in the future when the idealised feelings are transferred to another. These dynamics are interchangeable and the consultant may be perceived as a persecutory figure during some stages of the relationship but will be idealised at other times. The experience of a consistent, stable relationship figure who is able to hold and contain the patient's projections, particularly those of anger and anxiety but also of idealisation, may eventually support the development of the patient's ability to manage their own anxieties.

Frequent, superficial relationships trigger attachment need, fear of rejection or abandonment and confirmation of the patient's unconscious anxiety that they are unlovable and too 'bad' to be in a relationship. Many patients will never have experienced long-term relationships, involving opposition and anger as well as understanding and containment, and the forensic setting may offer the first opportunity for this.

A significant part of rehabilitation and management of forensic populations involves containment and establishing boundaries that have been absent in the lives of many individuals. This could be seen as directly paralleling the parenting process. Part of this includes the patient testing out boundaries, unconsciously needing to know that the relationship may be secure enough to tolerate their anxiety. Arguably it is part of the consultant's (and team's) role to tolerate and 'survive' the distress and anxiety within the relationship.

Responding to change of consultant requests without considering the presence of these dynamics may directly feed into the patient's unconscious belief that their inner anxieties are intolerable to others and reconfirm their inner experience of abusive and rejecting care.

Dilemmas associated with changes in RMO

Clinical issues

A decision to change resonsible medical officer (and hence clinical team) or to retain the status quo has positive as well as potentially negative consequences.

Therapeutic impasse: 'a change is as good as a rest'

Within forensic services, there are a number of patients who have complex needs and treatment resistance. These individuals may, over a protracted period of time, reach an impasse with their RMO and clinical team that does not resolve. In addition, clinical team members are sometimes unable to agree on management plans and these differences become irreconcilable. In these cases a change of RMO may carry distinct advantages. It should be recognised, however, that the transition period might be a time of increased risk for the service and a period of stagnation and frustration for the patient.

Threats to the RMO

When a patient persistently makes threats against the RMO (or a team member), a change of officer may become necessary. This should be considered both to protect the safety of the staff and also in the best interests of the patient, whose recovery will be compromised if psychiatric staff are unable to see them safely to conduct assessments and hence make decisions related to their care.

Delusional beliefs

A decision to change RMO due to a patient's delusional belief about them, for example delusions of love, should

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address the likelihood that the delusion will resolve with adequate treatment, the possibility that it will transfer to the new officer and the risk of harm to the officer while the psychotic symptoms persist. Arguably, the presence of the RMO throughout the patient's psychotic episode, and despite their delusional beliefs, may offer therapeutic benefit in challenging the patient's belief, particularly as the patient recovers.

Risk management

The process of changing RMO (and hence clinical team) must take risk management into account. This depends on the context of the particular case and the specific reasons given for the request by the patient, in addition to the team's understanding of what lies behind it. Keeping the same consultant team allows continuity of communication that goes beyond the written record. This includes a working knowledge of the context of potentially risky behaviours demonstrated since admission as well as historical risk data preceding admission. Knowledge of subtle changes of mental state can take considerable time to acquire and is easily lost when patients are transferred to a new team.

The clinical team may better appreciate many of the factors relating to risk than the patient making the request. For example, a patient with psychotic symptoms may feel that they should have unescorted community leave, whereas the team are aware that their symptoms are related to their offending behaviour and that the patient requires an escort on leave to manage this risk.

Team experience v. patient preference

A patient may request a change of RMO when there is a divergence between what the patient wants and what the team thinks they need. For example, the patient may wish for treatment A, which the team know was ineffective in the past, and may reject treatment B, which had previously led to full recovery. This scenario is unlikely to change if the patient changes RMO, but has potential to increase the patient's sense of helplessness and frustration. This may lead to escalations in problem behaviour and risk, deterioration in mental state and rapid disengagement from the team.

Organisational issues

The risk issues to be considered in analysing requests for a change in RMO extend beyond the individual patient. Patients unhappy with their team may, through voicing their negative comments, undermine the confidence of other patients in their clinical team.

The relationship of the clinical team with the patient's carers should not be disregarded. A change of team will also mean that the family/carers will need to establish new relationships with professionals.

At a service provision level, the assessments resulting from numerous requests for change in RMO are time consuming. An unanticipated consequence for under-resourced services is that this may draw clinicians away from other clinical business, resulting in risk management implications for the service.

Box 1. Procedure for change of responsible medical officer (RMO)

- A patient may ask to change their RMO and this request (after team discussion) will be taken to the weekly site-wide referral meeting by the current RMO.
- The referral will be discussed at this meeting and an assessment for this change will be conducted by another RMO on site. The assessing officer must have capacity within their clinical team and beds on the appropriate unit to allow the transfer of the patient to their team, if this becomes the preferred option.
- It is the responsibility of the referring RMO to provide up-to-date clinical information (recent medico-legal report, care programme approach documentation, etc.) to the assessing RMO.
- The assessing RMO will see the patient and will provide a letter to the patient with a copy to the referring RMO. This letter will include information about the patient's reasons for wishing to change RMO, an assessment of the current clinical picture and a discussion, in broad terms, of the likely treatment strategy that the patient would be involved in if the assessing RMO were to take over clinical responsibility for their care.
- The patient will have the opportunity to discuss this report with the advocacy service and/or any member of the clinical or nursing team. On the basis of this report and discussion, the patient will decide whether or not they still wish to change their RMO.
- Patients may only apply to change their RMO once every 2 years.

A change in RMO invariably necessitates a change in the whole clinical team, which subsequently alters all aspects of a patient's care. RMOs must have capacity within the team to accommodate such change. The availability of alternative officers is often limited if not by simple numbers than by geographical catchment area or area of specialisation.

If a service is to offer patients the opportunity to change RMO, then the possibility to move must be realistic and transparent. The reasons for wanting the change should be explicit and any assessment for change should look at these objectively. The process should involve feedback to the patient about the assessor's opinion on the patient's current treatment needs, relevant risk issues and how the current team may manage these areas.

Finally at a service and national level, it is important to recognise that regardless of whether or not patients change teams, such decisions will always need to be considered within the wider context of risk.

Change of RMO protocol

In considering the above issues, we have produced a protocol on managing change of RMO requests (Box 1), which is currently being piloted within a regional forensic in-patient service.

Conclusions

It would be difficult to argue against the current choice agenda within the NHS. However, this seemingly

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straightforward issue is more complex within the realm of psychiatry, particularly forensic practice. The choice agenda could be seen as a new reincarnation of an old clinical dilemma, that of balancing autonomy with the limitations of freedom accompanying detention under mental health legislation.

What is required is a sophisticated understanding of all the dynamics highlighted here, including clinical, risk and resource issues. It is hoped that such an understanding will allow patients genuine choice in the complex contexts within which they receive care.

Declaration of interest

None.

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***Caroline Jacob** Specialist Registrar in Forensic Psychotherapy, Langdon Hospital, Dawlish EX7 ONR, email: caroline.jacob@wlmht.nhs.uk, **Eluned Dorkins** Consultant Forensic Psychiatrist, Langdon Hospital, Dawlish, **Helen Smith** Consultant Forensic Psychiatrist, Langdon Hospital, Dawlish

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PAMELA ASHURST

On listening to the patient: Commentary on . . . The long case is dead†

> 'May I never see in the patient anything but a fellow creature in pain. May I never consider him merely a vessel of the disease' Maimonides (1135–1204)

I accepted the invitation to comment on the Editorial by Benning & Broadhurst (2007, this issue) with some trepidation. Since retiring from the NHS in 1993 I have lacked (and missed) the regular contact with trainees both pre- and post-Membership that was an important aspect of my clinical practice. Nevertheless I have long experience of the examination system as examinee, examiner and observer, and I do have opinions about it

Should the long case be retained in the MRCPsych Part II examination? Is it fair? Certainly every long case is different and issues such as the venue affect the choice of patients, for example alcoholism in Scotland, or chronic psychosis where there are any long-stay beds remaining. Regional variations in accent and dialect can greatly add to problems of comprehension and how much more difficult that must be for the increasing number of young doctors for whom English is not their first language. The use of actors as simulated patients alleviates that problem. Their diction is clear, they know the storyline and they are well-schooled in the psychopathology which they need to convey. And objective structured clinical examinations (OSCEs) are now established as the clinical arm of the MRCPsych Part I.

In many ways, then, OSCEs can provide an answer to the perennial problems that beset the organisers and the examination system. Actors don't default or they won't be paid. They don't need to occupy hospital facilities or hospital staff time. No need for up-to-date case histories in all their (often contradictory) complexity, with ICD–10 and DSM–IV underpinning the diagnoses. How much easier to invent a narrative for the actor, then leave him (or her) to develop the scenario in the best tradition of modern theatre, interacting with the co-lead (or examinee) with a captive audience (the examiner/critic) who will mark the performance according to an agreed format. However, the OSCEs have been considered unsuitable for the assessment of more advanced psychiatric clinical skills, and this conclusion (Hodges *et al*, 1999) was justification for retaining the use of the long case in the Part II examination (Tyrer & Oyebode, 2004).

It must be tempting to use actors to simulate the long clinical case. But real clinical practice is not easy, nor is it fair. Patients in all their infinite variety are unique and individual, challenging and difficult. They are what psychiatric practice is all about and this is precisely the problem if the long clinical case is lost.

The old Maudsley-style formulation, with its focus on the three 'Ps' (predisposing, precipitating and perpetuating) in the psychodynamic contribution to aetiology, was and remains an important aid in considering diagnosis and management in the long case, as in everyday clinical practice. The candidate is required to think analytically, to reflect and to draw conclusions. There is interaction between patient and candidate in the long case, requiring more than information-gathering or picking out

†See pp. 441–442, this issue.