the columns

correspondence

Regulatory burden in research

I would like to highlight difficulties we have experienced, in the hope that this will help others. We are taking part in a multicentre study which was approved by the multicentre research ethics committee in August 2005. In Bristol we are studying patients attending hospital clinics and a group from primary care.

Both site-specific assessments and R&D approval resulted in months of delays. Advice that we could not quote the primary care trust as a site (i.e. we needed to list surgeries that had agreed to take part) later turned out to be wrong. It was also unclear from guidance from the Central Office for Research Ethics Committees (COREC) that site-specific applications are not considered by the main ethics committee, but by subcommittees which meet more frequently.

Both R&D departments involved advised that an honorary contract was required prior to any patient contact, in addition to my NHS contract with the local mental health trust. An honorary contract with one was not acceptable to the other, in contravention of Department of Health guidance: 'where a researcher works across many NHS organisations they should not have to obtain multiple contracts' (http://www.bartsandthelondon.org.uk/research/honorary_contracts.asp). Both departments required separate Criminal Records Bureau checks and occupational health clearance, causing significant delays.

As an aspiring young academic psychiatrist this has been a discouraging start to my research career. There has been much debate about the regulatory and bureaucratic burden in research and the need to find a balance with safety so that research in the UK is not stifled. Sadly this does not seem to have been put into practice yet.

Lindsey Sinclair Clinical Research Fellow in Psychopharmacology, Psychopharmacology Unit, Bristol Royal Infirmary, Bristol BS2 8HW, email: Lindsey.sinclair@bristol.org.uk

Sexual abuse of patients by psychiatrists

I was pleased to read Dr Kennedy's review of the Kerr/Haslam Inquiry (*Psychiatric Bulletin*, June 2006, **30**, 204–206) and Dr Subotsky's response on behalf of the College (*Psychiatric Bulletin*, June 2006, **30**, 207–209). Dr Subotsky referred to sexualised behaviour between doctors and patients having been made criminal.

The Sexual Offences Act 2003 introduced significant changes to the law by introducing a new offence of sexual activity with a person with mental disorder impeding choice. This offence requires proof of sexual touching and that the individual was unable to refuse because of or for a reason related to a mental disorder. In addition, it must be proven that the perpetrator knew or could reasonably have been expected to know that the victim had a mental disorder (Stevenson *et al*, 2004). The key factor in determining whether it is possible to bring a safe conviction will hinge around capacity to refuse unwanted sexual activity. This is not defined in the Act (British Medical Association, 2004). For people with mental illness, where capacity is likely to fluctuate, it may be difficult to prove what their mental state was at the time of the alleged offence. Although well intentioned, in practice the law may be difficult to implement.

Clinicians should be aware that they or their colleagues may be arrested on a charge of rape should they decide to have sexual intercourse with their patients. Doctors will always be in the position of having more choice in these situations than their patients. For this reason, it is right that the College continues to deem that relationships of sexual intimacy between doctor and patient are totally unacceptable (Royal College of Psychiatrists, 2002).

BRITISH MEDICAL ASSOCIATION (2004) *Assessment of Mental Capacity – Guidance for Doctors and Lawyers*. London: BMJ Books.

ROYAL COLLEGE OF PSYCHIATRISTS (2002) *Vulnerable Patients, Vulnerable Doctors: Good Practice in Our Clinical Relationships* (Council Report CR101). London: Royal College of Psychiatrists.

STEVENSON, K., DAVIES, A. & GUNN, M. (2004) *Blackstone's Guide to The Sexual Offences Act 2003*. New York: Oxford University Press.

Kate Lovett Consultant Psychiatrist, South Hams Community Mental Health Team, Ivybridge, Devon PL21 9AB, email: kate.lovett@pcs-tr.swest.nhs.uk

Psychotherapeutic skills and College requirements

Pretorius & Goldbeck (*Psychiatric Bulletin*, June 2006, **30**, 223–225) commented on difficulties encountered by psychiatric specialist registrars in fulfilling the College requirements for experience of psychotherapy (Royal College of Psychiatrists, 2003). To determine the extent of the problem in Merseyside, we performed a survey of the psychotherapy experience of 73 trainee senior house officers (SHOs). Only 31 (42%) were aware of College requirements. Five trainees (7%) had conducted a long-term individual case and 41 (56%) at least a short-term case. Of those who had cases allocated, 21 (29%) had one short case, 11 (15%) had two short cases and 9 (12%) had three short cases or more. Of 11 trainees who sat their MRCPsych part II examination in March 2006, only 2 (18%) fulfilled the College requirements for psychotherapy experience. Only 14 trainees (19%) expected to fulfil the requirements by the time they were to sit their MRCPsych part II examination.

Of the 73 placements, 49 posts (67%) had supervision by a consultant psychotherapist. These included a Balint group, which most trainees had to do in their first two placements. The other trainees were not receiving supervision by a psychotherapist at the time of the survey. Our findings are consistent with those of Webb (2005) from Nottingham, Dharmadhikari (2006) from Leeds and Pretorius & Goldbeck (2006) from Scotland.

With the current 3- to 4-year training scheme it is difficult for trainees to fulfil College requirements. Pretorius & Goldbeck (2006) found that organisational changes have improved exposure to psychotherapy in different modalities. It is hoped that with improved planning, the

https://doi.org/10.1192/pb.30.9.352 Published online by Cambridge University Press